Chapter 5: Capturing Data and Information to Understand the Community of Care

Overview: This Chapter addresses the following questions: What kinds of patient data and information need to be captured to enable the reengineered Military Health System function effectively? What is the importance of such data and information in the new system? What are standard procedures and forms used to capture patient data and information? How will electronic files containing patient data and information be managed and maintained?

The Chapter is divided in the following sections:

Part A: Data/Information/Knowledge/Wisdom Paradigm

Part B: The Potential of Medical Informatics

Part C: Bad Data Results in Disease and Death

Part D: Medical Records:

1. *Medical Records*
   - Training Support Package Number HPABG022, entitled "Medical Records I"
   - Training Support Package Number HPABG023, entitled "Medical Records II"

2. *Medical Histories*
   - Recording Medical Histories – An Overview
   - Obtain and Record Medical History
   - Performance Checklist
   - Lesson Plans:
     - Plan of Instruction – Recording a Medical History
     - Teaching Guide – Physical Examination Techniques and Procedures
   - Patient History Scenarios
   - Common Terms
   - Recording Medical Histories
     - Section A. The PCM Technician
     - Section B. Reviewing the Basics
     - Section C. Practice Exercise, Problem-Oriented (Short)

3. *Charting Specific Health Problems*
   - Standard Chart
   - Two-day blood pressure
   - Ankle injuries
   - Cholesterol
   - Coumadin
   - Ear pain
   - Low back pain

- Sore throat
- URI
- UTI
- Vaginal discharge
- Vomiting and diarrhea

Cross-References: **(Medical Records)**

- Administrative Technician: Roles and Responsibilities as part of the Primary Care Team, see Chapter 3, Part B
- Anatomy and Physiology, see Appendix F
- Automated Systems and Productivity Tools, see Appendix D
- Evidence-Based Medicine, see Chapter 1, Part H
- Medical Technicians: Roles and Responsibilities as part of the Primary Care Team, see Chapter 3, Part B
- Nurses: Roles and Responsibilities as part of the Primary Care Team, see Chapter 3, Part B

Part E: Medical Records Management

- Training Support Package Number HPABG024, entitled "Medical Records Management"

Part F: Diagnostic/Procedural Coding

- Training Support Package Number HPABG002, entitled "Diagnostic/Procedural Coding"

Part G: Maintenance of Medical Regulating Transaction Files

- Training Support Package Number HPABG72D, entitled "Maintenance of Medical Regulating (MEDREG) Transaction Files

Part H: Managing Patient Transactions Using Medical Patient Accounting and Reporting

- Training Support Package Number HPABG028, entitled, "Managing Patient Transactions Using Medical Patient Accounting and Reporting (MEDPAR)

- Training Support Package Number HPABG029, entitled, "Managing/Producing Medical Patient Accounting and Reporting (MEDPAR) Reports"

PART A: DATA/INFORMATION/KNOWLEDGE/WISDOM PARADIGM

(No information or documents received on this topic.)

PART B: THE POTENTIAL OF MEDICAL INFOMATICS

(No information or documents received on this topic.)

PART C: BAD DATA RESULTS IN DISEASE AND DEATH

(No information or documents received on this topic.)

PART D: MEDICAL RECORDS

1. *Medical Records*

The Army developed two training programs for medical records administrators. The purpose of the first training program is to educate administrators in the construction, storage, and care of medical records. The second program teaches medical records administrators the proper filing of forms and documents to create Army medical records, including the filing of authorization forms.

Although the Army developed the training materials, the content is equally applicable and usable throughout the Military Health System.

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG022
TSP Title	Medical Records I
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for: MEDICAL RECORDS 1

This TSP
Contains

TABLE OF CONTENTS

HPABG022 version 1 / Medical Records I
28 May 1998

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
513-71G10	Patient Admin Specialist
513-71G10 (RC)	Patient Admin Specialist (RC)

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0200	Prepare a DA Form 3444 or 8005 Series Folder
081-866-0201	Prepare a Temporary Medical Record
081-866-0202	Prepare an Ambulatory Procedure Visit (APV) Record

Academic Hours

The Academic hours required to teach this TSP are as follows:

	ADT Hours/Methods
	4.0 / Conference / Discussion
Test	0.0 /
Test Review	0.0 /
Total Hours:	4.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
None	

Clearance Access

Security Level : Unclassified
Requirements: There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
AR 40-2	Army Medical Treatment Facilities: General Administration (Reprinted w/Basic Incl C 1-2, 15 Mar 83) (03 Mar 78)	01 Jan 1900	
MCHO-CL-P (40)	MEDCOM Memorandum	16 Oct 1997	
AR 40-66	Medical Record Administration (20 Jul 92)	01 Jan 1900	
AR 40-3	Medical, Dental, and Veterinary Care (15 Feb 85)	01 Jan 1900	

Student Study Assignments

None

Instructor Requirements

One (1) MOS 71G Qualified Instructor

Additional Personnel Requirements

None

Equipment Required for Instruction

Name	Quantity	Expendable
Screen, Projector	0	No
Projector, Still, 35mm	0	No

Materials Required

Instructor Materials:
Pointer
35mm slide projector, hand control, and screen
Slides HPABG022 01-56

Student Materials:
Student handout "Medical Records I Student Handout", M HPABG022 01.

Classroom, Training Area, and Range Requirements

CLASSROOM 44 PER, TABLES

Ammunition Requirements	**Name**	**Student Qty**	**Misc Qty**
	None		

Instructional Guidance

NOTE: Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material.

The Instructor should distribute student handouts prior to the start of classroom presentation.

Proponent Lesson Plan Approvals	**Name**	**Rank**	**Position**	**Date**

SECTION II. **INTRODUCTION**

Method of Instruction: Conference / Discussion
Instructor to Student Ratio is: 1:45
Time of Instruction: 4 hrs
Media: PRINT

Motivator

Your job as a Patient Administration Specialist requires a knowledge of many things, but none more important than your knowledge of medical records. To be at the top of your field requires you to constantly strive for perfection in maintaining medical records.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Define the scope of medical records administration
Conditions:	Given AR 40-2, Army Medical Treatment Facilities General Administration, AR 40-3, Medical, Dental, and Veterinary Care, and AR 40-66, Medical Record Administration, DA Form 3444-Series Folder, MEDCOM Memorandum MCHO-CL-p (40), DA Form 8005-Series Folder
Standards:	The soldier must define the scope of medical records administration IAW AR 40-2, AR 40-3 and AR 40-66.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Treatment is important in a Medical Treatment Facility (MTF), but there is an old saying, "The job's not complete until the paperwork's done". Well, that sure applies to the field of medicine. In this field the primary paperwork is so important that the many pieces are carefully gathered together into one folder that is stored and filed as a patient's medical record. Your knowledge of and skill with medical records is essential to ensure patients receive the current and future care they require. A medical record is not just a bunch of papers thrown together; it is the documented history of the emotional and physical well being of an individual. This lesson will begin your study on the construction, storage, and care of medical records.

Slide S HPABG022 01: MEDICAL RECORDS I

SECTION III. PRESENTATION

A. ENABLING LEARNING OBJECTIVE A

ACTION:	Define the purpose of medical records.
CONDITIONS:	Given AR 40-66
STANDARDS:	The soldier must define the purpose of medical records IAW AR 40-66.

1. Learning Step / Activity 1. Purpose of medical records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 02: Medical Records: Purpose

a. Provides a complete, concise medical and dental history for patient care.
b. Provides a source of patient information for Army programs.
   (1) Physical Evaluation Board.
   (2) MOS/Medical Retention Board.
   (3) Personnel Reliability Program.

Slide S HPABG022 03: Medical Records: Purpose

c. Provides a medico-legal support.
   (1) Legal rights of the patient.
   (2) Legal rights of the government.
d. Provides data for medical research and continuing education.

Slide S HPABG022 04: Medical Records: Purpose

e. Provides documentation for hospital accreditation.
   (1) Standards are set by the Joint Commission for Accreditation of Hospital Organizations (JCAHO).
   (2) Surveys and recommendations for improvement are made by JCAHO.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Status of medical record information.

Method of Instruction: Conference / Discussion

Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 05: Medical Records: Status

a. "Private and confidential".
b. Used in diagnosis, treatment, and prevention of medical dental conditions.
c. Private; people not involved in a patient's care or in medical research shall not have access to a patient's medical records.
d. Legal documents; may be used as evidence in legal actions.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Coordination and responsibilities for medical records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 06: Medical Records: Coordination and Responsibilities

a. MTF and DENTAC commanders: official custodians of health records (HRECs) for members of units for which they provide primary medical and dental care.
b. Unit commanders: ensure that HRECs are always available to medical department personnel.

Slide S HPABG022 07: Medical Records: Coordination and Responsibilities

c. RC unit commanders: (receiving medical care from civilian sources) may act as custodians of their unit's HRECs only if no Army Medical Department (AMEDD) personnel are locally available.
d. Military personnel officers: ensures personnel changing station carry their HREC; where deemed inappropriate, forwards the HREC to the soldier's next station.

Slide S HPABG022 08: Medical Records: Coordination and Responsibilities

e. Patient Administration Chief: acts for the MTF/DENTAC commander in matters pertaining to medical records.

f. Health care providers: record all patient observations, treatments, and care, promptly and correctly.

(1) Must be clinically pertinent.

(2) Must be legible; should be typed, but may be handwritten. (Radiology, pathology, operative reports, and Narrative Summary Reports must be typed).

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	Select the appropriate type of record for different patient categories.
CONDITIONS:	Given AR 40-66 and AR 40-3
STANDARDS:	The soldier must select the type of record for category of patient for which it is prepared IAW AR 40-66 and AR 40-3.

1. Learning Step / Activity 1. Types of patient records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 10: Medical Records: Types

a. Health Record (HREC).
b. Outpatient Treatment Record (OTR).
c. Inpatient Treatment Record (ITR).
d. U.S. Field Medical Card (FMC).

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Health Records (HREC)

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 11: Medical Records: Health Records

a. Used in outpatient medical care.
b. Used in inpatient medical care.

Slide S HPABG022 12: Medical Records: Health Records

c. Categories of personnel for whom health records are prepared:
(1) Active duty personnel (Army, Navy, Marine, Air Force, Coast Guard)
(2) Reserve components (USAR/ARNG)
(3) Cadets of U.S. Military Academies
(4) Military prisoners while in confinement

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Outpatient Treatment Records (OTRs)

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 13: Medical Records I: OTR

a. Used for each patient treated as an outpatient at a U.S. Army MTF and Dental Treatment Facility for whom a HREC is not prepared.
b. Categories for whom outpatient treatment records (OTRs) are prepared:
(1) Family members of active duty and retired personnel.
(2) Retired personnel.
(3) Civilian beneficiaries/civilian emergencies.

Slide S HPABG022 14: Medical Records I: OTR

c. Given to physicians, dentist, and other medical personnel attending an outpatient.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Inpatient Treatment Records (ITRs)

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 15: Medical Records I: ITR

a. Used for each patient admitted at a U.S. Army MTF.
b. Categories for whom ITRs are prepared:
    (1) All categories of patients.

Slide S HPABG022 16: Medical Records I: ITR

c. Given to physicians, dentist, and other medical personnel attending an inpatient.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. U.S. Field Medical Card (USFMC)

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 17: Medical Records I: FMC

a. Used primarily in field or combat situations where health records are not available.
b. Used for all categories of combat personnel, not just active duty.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	Prepare a DA Form 3444-Series Folder and DA Form 8005-Series Folder.
CONDITIONS:	Given AR 40-2, AR 40-66, DA Form 3444-Series Folder, DA Form 8005-Series Folder, colored tape, and DOD identification card
STANDARDS:	The soldier must prepare a DA Form 3444-Series and DA Form 8005-Series Folder IAW AR 40-2 and AR 40-66.

1. Learning Step / Activity 1. Selecting a folder color.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45

Media: PRINT

Slide S HPABG022 18: Medical Records I: Series 3444-Series

Slide S HPABG022 19: Medical Records I: Series 8005-Series

Slide S HPABG022 20: Medical Records I: Folder Color

a. Determine the last two digits of the patient's SSN (the primary group).
b. Select the correct folder color (10 colors available) according to the patient's primary group (Table 1).

Slide S HPABG022 21: Medical Records I: Folder Color

Primary Group	Color	DA Form
00-09	Orange	3444 or 8005
10-19	Light green	3444-1 or 8005-1
20-29	Yellow	3444-2 or 8005-2
30-39	Gray	3444-3 or 8005-3
40-49	Tan	3444-4 or 8005-4
50-59	Light blue	3444-5 or 8005-5
60-69	White	3444-6 or 8005-6
70-79	Brown	3444-7 or 8005-7
80-89	Pink	3444-8 or 8005-8
91-99	Red	3444-9 or 8005-9

Folder Color
Table 1

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Labeling the patient's identification on the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 22: Medical Records I: Labeling

a. Put an identification label in the "Patient Identification" block of the folder.
(1) Use the patient's recording card.
(2) If the recording card is not available, type or print (blue or black ink) the patient's name, rank, grade, family member prefix, sponsor's SSN,

patient's SSN, date of birth, the code for the MTF that maintains records, and register number.

Slide S HPABG022 23: Medical Records I: Labeling

b. For written entries on the folders, a fiber-tipped pen or other marking device should be used; do not use a pencil or regular pen.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Coding the Social Security Number and Family Member Prefix.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 24: Medical Records I: SSN

FMP	If the Patient Is the:
01	Sponsor's oldest child.
02	Sponsor's next oldest child.
03	Sponsor's third oldest child.
04, 05, and so on through 19	Sponsor's fourth oldest child through--
20	The SPONSOR
30 to 39 series	Sponsor's spouse or former spouse.
40	Sponsor's mother or stepmother.
45	Sponsor's father or stepmother.
50	Sponsor's mother-in-law.
55	Sponsor's father-in law.
60, 61, and so on through 69	Another relative.
90-95	Beneficiary assigned by statue.
98	Civilian brought to the MTF.
99	All others not elsewhere.

Assignment of FMP
Table 2

Slide S HPABG022 25: Medical Records I: SSN

a. Code the patient's SSN on the folder.

(1) Use 1 inch of black tape. Code the last digit of the SSN on the numbers on the right side and/or top of the folder by placing the tape over the number and wrapping it around the folder so that it covers the same number on the back of the folder. If tape is not available, the number may be blocked out with black ink.

Slide S HPABG022 26: Medical Records I: SSN

(2) Enter the last digit of the SSN in the far right block on the upper, top edge of the folder.
(3) Enter the two digits of the secondary group in the two empty blocks in the upper right corner to the left of the primary group numbers.
(4) Enter the remaining digits of the SSN in the five hyphenated blocks along the top of the folder.

Slide S HPABG022 27: Medical Records I: SSN

b. Enter the Family Member Prefix (FMP) number (Table 2) in the circles to the left of the tertiary numbers of the SSN.

FMP	If the Patient Is the:
01	Sponsor's oldest child.
02	Sponsor's next oldest child.
03	Sponsor's third oldest child.
04, 05, and so on through 19	Sponsor's fourth oldest child through--
20	The SPONSOR
30 to 39 series	Sponsor's spouse or former spouse.
40	Sponsor's mother or stepmother.
45	Sponsor's father or stepmother.
50	Sponsor's mother-in-law.
55	Sponsor's father-in law.
60, 61, and so on through 69	Another relative.
90-95	Beneficiary assigned by statue.
98	Civilian brought to the MTF.
99	All others not elsewhere.

Assignment of FMP
Table 2

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Code the folder's retirement date.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 28: Medical Records: Retirement Colors

YEAR RECORD IS TO BE RETIRED	TAPE COLOR
1995	Red
1996	Blue
1997	Green
1998	Yellow
1999	Silver or White
2000	Black
2001	Orange
2002	Red

Retirement Year Tape Colors
Table 3

Slide S HPABG022 29: Medical Records: Retirement Colors

a. On Inpatient Treatment Records (ITR) and Outpatient Treatment Records (OTR), to indicate the retirement year of the record, place a piece of 1/2" long tape, of the proper color IAW Table 2, over the letters "R" (retirement year) at the top of the folder and along the right edge of the folder.
b. Bend the tape over the edge of the folder so that it also covers the "R" on the backside.

NOTE: The letters are repeated on the top and edge of the folder to allow for different folder filing positions.

NOTE: The retirement date for OTRs will be 3 years after the end of the year in which the last medical treatment was given. ITRs will be retired after 5 years if a teaching hospital, and retired after 1 year if a non-teaching hospital. Health records are not retired.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Code the patient's "status".

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 30: Medical Records: Patient Status

RECORD TYPES	GENERAL GROUP
COLOR	
HRECs	Active duty military and RC personnel
Red	
DENTAL HRECs	on active duty or active duty training
for	
	more than 30 days.
Military ITRs	Military records (ITR)
Red	
Military Outpatient Records	Military other than active duty and
RC Green	
Military Dental Files	personnel on active duty or active
duty	
	training for less than 30 days.
Foreign and NATO ITRs	Foreign nationals and NATO
Silver or	
Foreign and NATO Dental Files	
White	
	All others
Black	

Tape Color Denoting Patient Status
Table 4

Slide S HPABG022 31: Medical Records: Patient Status

a. Show the status of the patient by putting a piece of 1/2" long tape, of the proper color IAW Table 3, over the letters "S" at the top of the folder and along the right edge of the folder.
b. Bend the tape over the edge of the folder so that it also covers the "S" on the backside.

NOTE: Conduct a check on learning and summarize the learning activity.

6. Learning Step / Activity 6. Completing the remaining boxes and blocks on the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 32: Medical Records: Remaining boxes

a. Under the "Type of Record," check the proper box to show how the folder will be used.
b. Check the proper box under the "Note to Physician," if needed.
c. If known, enter the patient's blood type in the "Blood Type" blank.

Slide S HPABG022 33: Medical Records: Remaining boxes

NOTE: When the size of an individual medical record requires the creation of another folder, the folders will be labeled by volume numbers, e.g., "Vol. 1 of 2, Vol. 2 of 2". When one folder is removed from the file, all folders will be removed and kept together.

NOTE: Conduct a check on learning and summarize the learning activity.

7. Learning Step / Activity 7. The Privacy Act Statement.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 34: Medical Records: Privacy Statement

a. Patient completes the "signature, sponsor's SSN, and date" blocks of the Privacy Act Statement (DD Form 2005) on the inside of the rear flap of the folder.

b. If the patient's DD 2005 is already completed, they do not need to complete a new one.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

D. ENABLING LEARNING OBJECTIVE D

ACTION:	Prepare a Temporary Medical Record.
CONDITIONS:	Given AR 40-66, manila folder, and DOD identification card.
STANDARDS:	The soldier must prepare a Temporary Health Record IAW AR 40-66.

1. Learning Step / Activity 1. Prepare a temporary medical record.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 35: Medical Records: Temporary Record

a. Use a manila folder rather than a DA Form 3444-series or DA Form 8005-series.
b. Initiate DD Form 2005 (Privacy Act Statement-Health Care Records).
c. File DD Form 2005 in the temporary record.
d. Print the patient's name on the folder.

Slide S HPABG022 36: Medical Records: Temporary Record

e. Print the patient's social security number on the folder.
f. Print the date the temporary record is initiated on the folder.
g. File documents on the person's medical condition as they are used.
h. File forms from the temporary treatment record into the applicable HREC, when it is received.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

E. ENABLING LEARNING OBJECTIVE E

ACTION:	Prepare an Ambulatory Procedure Visit (APV) Record.
CONDITIONS:	Given DA Form 3444-Series Folder or a manila folder, MEDCOM Memorandum, MCHO-CL-C (40): Ambulatory Procedure Visit (APV)
STANDARDS:	The soldier must prepare an Ambulatory Procedure Visit (APV) Record IAW MEDCOM Memorandum, MCHO-CL-C (40): Ambulatory Procedure Visit (APV)

1. Learning Step / Activity 1. Definition of an Ambulatory Procedure Visit (APV).

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 37: Medical Records: APV

a. The APV refers to a medical or surgical intervention requiring immediate (day of procedure), preprocedure, and immediate postprocedure care in an ambulatory procedure unit.
b. It is determined by the complexity, intensity, and duration of the care provided.

Slide S HPABG022 38: Medical Records: APV

c. A licensed or registered care practitioner will be directly involved in the health care intervention.
d. The total length of time that care is provided is less than 24 hours.

Slide S HPABG022 39: Medical Records: APV

NOTE: An Ambulatory Procedure Unit (APU) is one or more locations or freestanding outpatient clinics specially equipped, staffed, and designated for the purpose of providing the intensive level of outpatient care associated with APVs.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Complete the standard forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 40: Medical Records: APV

a. Complete the standard forms (SF), or other forms recommended for use in the APV record:

(1) Privacy Act Statement (DD Form 2005).
(2) Abbreviated Medical Record (SF 539).

Slide S HPABG022 41: Medical Records: APV

(3) An ongoing, interdisciplinary assessment of patient needs and patient plan of care which includes, but is not limited to: preprocedure and postprocedure patient instructions, to include a brief physician summary of care provided, and Advanced Medical Directives.
(4) Provider Orders (DA Form 5256).

Slide S HPABG022 42: Medical Records: APV

(5) Other relevant forms, as appropriate:
a) Patient Procedure or Operative Consent (SF 522).
b) Operative Report (SF 516).
c) Tissue Report (SF 515).
d) Anesthesia Record (SF 517).

Slide S HPABG022 43: Medical Records: APV

(f) Progress Notes (SF 509), and all appropriate therapeutic documentation, to include postprocedure follow-up telephone call.
(g) Medical Record-Emergency Care and Treatment Record (SF 558), if any APV occurs subsequent to treatment in an Emergency Department/Service
(h) All diagnostic reports, e.g., laboratory, radiology, or electrocardiogram reports, etc.

Slide S HPABG022 44: Medical Records: APV

NOTE: Documentation for the APV record must meet the standards for a short-term stay (abbreviated medical record) and must comply with current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) documentation standards.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Route the forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 45: Medical Records: Route Forms

a. Forward a copy of the patient's postprocedure instructions with a summary of care (e.g., SF 509 or SF 539, etc.) to the Health/Outpatient Treatment Record (HREC/OTR).

NOTE: Ensure you annotate the APV on the DA Form 5571 (Master Problem List).

Slide S HPABG022 46: Medical Records: Route Forms

b. File all documentation related to the APV in a DA Form 3444-series folder, on the left side of the inpatient folder.

NOTE: Store APV records in a limited access area of the MTF, e.g., the inpatient records section.

Slide S HPABG022 47: Medical Records: Route Forms

NOTE: Do not integrate the original APV record into the HREC/OTR.

NOTE: Retire APV records to the National Personnel Records Center IAW AR 25-400-2, The Modern Army Record keeping System (MARKS).

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

F. ENABLING LEARNING OBJECTIVE F

ACTION:	Prepare an Observation Record.
CONDITIONS:	Given a DA Form 3444-Series and Memorandum, MCHO-CL-P (40).
STANDARDS:	The soldier must prepare file forms for an Observation Record IAW Memorandum, MCHO-CL-P (40).

1. Learning Step / Activity 1. Definition of observation status.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 48: Medical Records: Observation Record

a. Observation patients are outpatients with acute or chronic medical problems who require assessment monitoring or diagnostic evaluation in order to determine final disposition.
b. The decision to place a patient in observation status is based upon the complexity, intensity, and duration of care required.

Slide S HPABG022 49: Medical Records: Observation Record

c. Observation stays generally should not exceed 23 hours, but up to 48 hours may be authorized when medical necessity has been clearly indicated.
d. Criteria for patients in observation status:
(1) Written orders.
(2) Documentation addressing diagnosis or reason for placement.
(3) Orders for patient care and therapeutics.
(4) Determination of final disposition.

Slide S HPABG022 50: Medical Records: Observation Record

e. Observation status is appropriate for all types of patients for whom the physician and nursing care requirements necessitate monitoring for short durations.
f. Observation status should not be a substitute for medically appropriate inpatient care such as step-down units or critical care beds.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Complete the standard forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 51: Medical Records: Observation Record

a. Complete the standard forms (SF), or other forms recommended for use in the Observation Record:
(1) Privacy Act Statement (DD Form 2005).
(2) Abbreviated Medical Record (SF 539).

Slide S HPABG022 52: Medical Records: Observation Record

(3) An ongoing, interdisciplinary assessment of patient needs and patient plan of care which includes, but is not limited to: preprocedure and

postprocedure patient instructions, to include a brief physician summary of care provided, and Advanced Medical Directives.
(4) Provider Orders (DA Form 5256).

Slide S HPABG022 53: Medical Records: Observation Record

(5) Other relevant forms, as appropriate:
a) Patient Procedure or Operative Consent (SF 522).
b) Operative Report (SF 516).
c) Tissue Report (SF 515).
d) Anesthesia Record (SF 517).
(f) Progress Notes (SF 509), and all appropriate therapeutic documentation, to include postprocedure follow-up telephone call.

Slide S HPABG022 54: Medical Records: Observation Record

(g) Medical Record-Emergency Care and Treatment Record (SF 558).
(h) All diagnostic reports, e.g., laboratory, radiology, or electrocardiogram reports, etc.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Route the standard forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG022 55: Medical Records: Observation Record

a. Forward a copy of the patient's postprocedure instructions with a summary of care (e.g., SF 509 or SF 539, etc.) to the Health/Outpatient Treatment Record (HREC/OTR).
b. File all documentation related to the Observation Record in a DA Form 3444-series folder, on the left side of the inpatient folder.

Slide S HPABG022 56: Medical Records: Observation Record

NOTE: Store Observation Records in a limited access area of the MTF, e.g., the inpatient records section.

NOTE: Do not integrate the original Observation Record into the HREC/OTR.

NOTE: Retire Observation Records to the National Personnel Records Center IAW AR 25-400-2, The Modern Army Record keeping System (MARKS).

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. **SUMMARY**

Method of Instruction: Conference / Discussion

Instructor to Student Ratio is: 1:45
Time of Instruction: 0 hrs
Media: PRINT

Review / Summarize Lesson

During this lesson, you were introduced to the purpose of medical records in the Army medical community. We discussed some of their purposes: medical history, medico-legal support, and source of patient information. We learned certain patient categories and types of records. Also, you participated in practical exercises completing terminal digit file folders, temporary medical records, ambulatory procedure visits, and observation records.

Check on Learning

Conduct a check on learning and summarize the lesson:

QUESTION: What are four types of Army medical records?
ANSWER: Health Record, Outpatient Treatment Record, Inpatient Treatment Record, and U.S. Field Medical Card

QUESTION: Who is responsible for initiating the US Field Medical Card for a military member injured on the battlefield?
ANSWER: The aid or corpsman who first treats the injured patient.

QUESTION: Who is responsible for ensuring that HRECs are always available to Army medical department personnel?
ANSWER: Unit Commander.

QUESTION: What is the DA Form 3444-Series?
ANSWER: A file folder in which medical record forms may be stored and filed.

SECTION V. STUDENT EVALUATION

NOTE: Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.

Testing Requirements

A written test (50 multi-choice and/or true/false questions) shall be administered testing knowledge of the lessons "Medical Records I". The student must score a minimum of 70 points to obtain a passing grade.

NOTE: Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

Feedback Requirement

PRACTICAL EXERCISE SHEET PE HPABG022 01

Title

Medical Records I - File Folder Preparation

Lesson Number/Title

HPABG022 version 1 / Medical Records I

Introduction

During the discussion portion of this lesson, we discussed the entries that are made on the DA Form 3444-Series and DA Form 8005-Series terminal digit file folders. During this practical exercise session, you will get the opportunity to actually complete several simulated file folders for fictitious patients.

Motivator

Your job as a Patient Administration Specialist requires a knowledge of many things, but none more important than your knowledge of medical records. To be at the top of your field requires you to constantly strive for perfection in maintaining medical records. As you will discover, medical records may by the very basis for continued good treatment of patients.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Define the scope of medical records administration
Conditions:	Given AR 40-2, Army Medical Treatment Facilities General Administration, AR 40-3, Medical, Dental, and Veterinary Care, and AR 40-66, Medical Record Administration, DA Form 3444-Series Folder, MEDCOM Memorandum MCHO-CL-p (40), DA Form 8005-Series Folder
Standards:	The soldier must define the scope of medical records administration IAW AR 40-2, AR 40-3 and AR 40-66.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Treatment is important in an MTF, but there is an old saying, "The job's not complete until the paperwork's done". Well, that sure applies to the field of medicine. In this field the primary paperwork is so important that the many pieces are carefully gathered together into one folder that is stored and filed as a patient's medical record. Your knowledge of and skill with medical records is essential to ensure patients receive the current and future care

they require. A medical record is not just a bunch of papers thrown together; it is the documented history of the emotional and physical well being of an individual. This lesson will begin your study on the construction, storage, and care of medical records.

Slide S HPABG022 01: MEDICAL RECORDS I

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
Photocopies of the front of a DA Form 3444-Series or DA Form 8005-Series; four (4) per student.

Student Materials:
Student handout "Medical Records I Student Handout", M HPABG022 01.

Special Instructions

Procedures

SITUATION:

You may consider that it is the year 1995 and that you are assigned to a Medical Records Branch, Patient Administration Division. Your duties require you to prepare, maintain, retrieve, and file terminal digit file folders for patients.

EXERCISE:

Using photocopies of terminal digit file folders, fill in the blocks and blanks for the terminal digit file folders and write the color for the folder across the front of the sheet for each of the patients' data below.
Obtain the materials necessary to complete the exercise from the classroom instructor.
You may use the information in the Student Handout to complete this exercise.
When you have completed all of the folder copies, turn them in to the instructor.

PATIENT DATA:

Bebak, Francis J., PV2, social security number 656-12-4454, blood type AB-. has been admitted to your facility for treatment for gastroenteritis.

Price, James A. is the first-born child of active duty CPT. John J. Price. CPT Price's SSN is 611-11-0305, Mrs. Price's SSN is 764-47-7305, and little James' SSN is 611-44-1289. Mrs. Price has brought James into your facility for outpatient treatment where he has no treatment folder.

Joe, George I., SSG, SSN 224-56-8294, Company A, 2nd BN, AHS requires treatment for a sprained ankle and his health record has been destroyed during a PCS move. His blood type is O+.

Marsh, George M., retired Army Major, Army service number 093-21-4788, SSN 437-89-0001, blood type AB+, is brought into your facility with a possible heart attack. He has no records on file. His wife is an active duty Marine Brigadier General, SSN 650-00-7853 with 27 years service.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 1

SITUATION:

You may consider that it is the year 1995 and that you are assigned to a Medical Records Branch, Patient Administration Division. Your duties require you to prepare, maintain, retrieve, and file terminal digit file folders for patients.

EXERCISE:

Using photocopies of terminal digit file folders, fill in the blocks and blanks for the terminal digit file folders and write the color for the folder across the front of the sheet for each of the patients' data below.
Obtain the materials necessary to complete the exercise from the classroom instructor.
You may use the information in the Student Handout to complete this exercise.
When you have completed all of the folder copies, turn them in to the instructor.

PATIENT DATA:

Bebak, Francis J., PV2, social security number 656-12-4454, blood type AB-. has been admitted to your facility for treatment for gastroenteritis.

Price, James A. is the first-born child of active duty CPT. John J. Price. CPT Price's SSN is 611-11-0305, Mrs. Price's SSN is 764-47-7305, and little James' SSN is 611-44-1289. Mrs. Price has brought James into your facility for outpatient treatment where he has no treatment folder.

Joe, George I., SSG, SSN 224-56-8294, Company A, 2nd BN, AHS requires treatment for a sprained ankle and his health record has been destroyed during a PCS move. His blood type is O+.

Marsh, George M., retired Army Major, Army service number 093-21-4788, SSN 437-89-0001, blood type AB+, is brought into your facility with a possible heart attack. He has no records on file. His wife is an active duty Marine Brigadier General, SSN 650-00-7853 with 27 years service.

PRACTICAL EXERCISE SHEET PE HPABG022 02

Title

Medical Records I - Temporary Medical Record Preparation

Lesson Number/Title

HPABG022 version 1 / Medical Records I

Introduction

Motivator

Your job as a Patient Administration Specialist requires a knowledge of many things, but none more important than your knowledge of medical records. To be at the top of your field requires you to constantly strive for perfection in maintaining medical records.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Define the scope of medical records administration
Conditions:	Given AR 40-2, Army Medical Treatment Facilities General Administration, AR 40-3, Medical, Dental, and Veterinary Care, and AR 40-66, Medical Record Administration, DA Form 3444-Series Folder, MEDCOM Memorandum MCHO-CL-p (40), DA Form 8005-Series Folder
Standards:	The soldier must define the scope of medical records administration IAW AR 40-2, AR 40-3 and AR 40-66.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Treatment is important in an MTF, but there is an old saying, "The job's not complete until the paperwork's done". Well, that sure applies to the field of medicine. In this field the primary paperwork is so important that the many pieces are carefully gathered together into one folder that is stored and filed as a patient's medical record. Your knowledge of and skill with medical records is essential to ensure patients receive the current and future care they require. A medical record is not just a bunch of papers thrown together; it is the documented history of the emotional and physical well being of an individual. This lesson will begin your study on the construction, storage, and care of medical records.

Slide S HPABG022 : MEDICAL RECORDS I

Resource Requirements

Instructor Materials:
Manila Folders, 9"x12', one (1) per student in the class.
DA Form 2005. with signature blanks completed, one (1) per student in the class.

Student Materials:
Student handout "Medical Records I Student Handout", M HPABG022 01.

Special Instructions

Procedures

SITUATION:
In the year 1997, you are a part of a deployed Patient Administration Division working out of tent facilities. You have several patients checking in for care, but you have none of their records.

EXERCISE:
Prepare temporary medical records for each of the patients listed below.
Obtain the materials necessary to complete the exercise from the classroom instructor.
You may use the information in the Student Handout to complete this exercise.
When you have completed all of the records, turn them in to the instructor.

PATIENTS:
Grayson, Richard R., SSGT, SSN: 222-55-8987 has come into the MTF because he caught his hand a door.
Peterson, Marilyn P., PVT, SSN 493-76-8462 wishes to be treated for a cold.
Macson, Mason M., Jr., Major, US Army, Retired, SSN 745-99-9988, son of Macson, Mason M., Sr., General, US Army, SSN 238-47-2395 is working as a civilian technical advisor to Army on a missile project is seeking treatment for a pain in his chest.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 2

SITUATION:
In the year 1997, you are a part of a deployed Patient Administration Division working out of tent facilities. You have several patients checking in for care, but you have none of their records.

EXERCISE:
Prepare temporary medical records for each of the patients listed below.
Obtain the materials necessary to complete the exercise from the classroom instructor.
You may use the information in the Student Handout to complete this exercise.
When you have completed all of the records, turn them in to the instructor.

PATIENTS:
Grayson, Richard R., SSGT, SSN: 222-55-8987 has come into the MTF because he caught his hand a door.
Peterson, Marilyn P., PVT, SSN 493-76-8462 wishes to be treated for a cold.
Macson, Mason M., Jr., Major, US Army, Retired, SSN 745-99-9988, son of Macson, Mason M., Sr., General, US Army, SSN 238-47-2395 is working as a civilian technical advisor to Army on a missile project is seeking treatment for a pain in his chest.

PRACTICAL EXERCISE SHEET PE HPABG022 03

Title

Medical Records I - Ambulatory Procedure Visit Record Preparation

Lesson Number/Title

HPABG022 version 1 / Medical Records I

Introduction

Motivator

Your job as a Patient Administration Specialist requires a knowledge of many things, but none more important than your knowledge of medical records. To be at the top of your field requires you to constantly strive for perfection in maintaining medical records.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Define the scope of medical records administration
Conditions:	Given AR 40-2, Army Medical Treatment Facilities General Administration, AR 40-3, Medical, Dental, and Veterinary Care, and AR 40-66, Medical Record Administration, DA Form 3444-Series Folder, MEDCOM Memorandum MCHO-CL-p (40), DA Form 8005-Series Folder
Standards:	The soldier must define the scope of medical records administration IAW AR 40-2, AR 40-3 and AR 40-66.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Treatment is important in an MTF, but there is an old saying, "The job's not complete until the paperwork's done". Well, that sure applies to the field of medicine. In this field the primary paperwork is so important that the many pieces are carefully gathered together into one folder that is stored and filed as a patient's medical record. Your knowledge of and skill with medical records is essential to ensure patients receive the current and future care they require. A medical record is not just a bunch of papers thrown together; it is the documented history of the emotional and physical well being of an individual. This lesson will begin your study on the construction, storage, and care of medical records.

Slide S HPABG022 : MEDICAL RECORDS I

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
35mm slide projector, hand control, and screen
Slides HPABG022 01-

Student Materials:
Student handout "Medical Records I Student Handout" , M HPABG022 01.

Special Instructions

Procedures

SITUATION:
In the year 1999, you are a part of an Ambulatory Procedure Unit associated with an MTF. Assume that your unit has patients requiring immediate (day of procedure), preprocedure, and immediate post procedure care.

EXERCISE:
Using your Medical Records I Student Handout, list the forms that may be possibly used in caring for the patients, and describe where you would file the forms.
When you have completed your list, turn it in to the instructor.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 3

SITUATION:
In the year 1999, you are a part of an Ambulatory Procedure Unit associated with an MTF. Assume that your unit has patients requiring immediate (day of procedure), preprocedure, and immediate post procedure care.

EXERCISE:
Using your Medical Records I Student Handout, list the forms that may be possibly used in caring for the patients, and describe where you would file the forms.
When you have completed your list, turn it in to the instructor.

PRACTICAL EXERCISE SHEET PE HPABG022 04

Title

Medical Records I - Observation Record Preparation

Lesson Number/Title

HPABG022 version 1 / Medical Records I

Introduction

Motivator

Your job as a Patient Administration Specialist requires a knowledge of many things, but none more important than your knowledge of medical records. To be at the top of your field requires you to constantly strive for perfection in maintaining medical records.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Define the scope of medical records administration
Conditions:	Given AR 40-2, Army Medical Treatment Facilities General Administration, AR 40-3, Medical, Dental, and Veterinary Care, and AR 40-66, Medical Record Administration, DA Form 3444-Series Folder, MEDCOM Memorandum MCHO-CL-p (40), DA Form 8005-Series Folder
Standards:	The soldier must define the scope of medical records administration IAW AR 40-2, AR 40-3 and AR 40-66.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Treatment is important in an MTF, but there is an old saying, "The job's not complete until the paperwork's done". Well, that sure applies to the field of medicine. In this field the primary paperwork is so important that the many pieces are carefully gathered together into one folder that is stored and filed as a patient's medical record. Your knowledge of and skill with medical records is essential to ensure patients receive the current and future care they require. A medical record is not just a bunch of papers thrown together; it is the documented history of the emotional and physical well being of an individual. This lesson will begin your study on the construction, storage, and care of medical records.

Slide S HPABG022 : MEDICAL RECORDS I

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
35mm slide projector, hand control, and screen
Slides HPABG022 01-

Student Materials:
Student handout "Medical Records I Student Handout", M HPABG022 01.

Special Instructions

Procedures

SITUATION:
In the year 1999, you are a part of a Patient Administration Branch associated with an MTF. Assume that your unit has outpatients with acute or chronic medical problems who require assessment monitoring or diagnostic evaluation in order to determine final disposition, therefore they are being placed in observation status.

EXERCISE:
Using your Medical Records I Student Handout, list the forms that may be possibly used in caring for the patients, and describe where you would file the forms.
When you have completed your list, turn it in to the instructor.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 4

SITUATION:
In the year 1999, you are a part of a Patient Administration Branch associated with an MTF. Assume that your unit has outpatients with acute or chronic medical problems who require assessment monitoring or diagnostic evaluation in order to determine final disposition, therefore they are being placed in observation status.

EXERCISE:
Using your Medical Records I Student Handout, list the forms that may be possibly used in caring for the patients, and describe where you would file the forms.
When you have completed your list, turn it in to the instructor.

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG023
TSP Title	Medical Records II
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for:

This TSP
Contains

TABLE OF CONTENTS

HPABG023 version 1 / Medical Records II
28 May 1998

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
513-71G10	Patient Admin Specialist
513-71G10 (RC)	Patient Admin Specialist (RC)

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0203	Prepare an Observation Record
081-866-0204	File Authorized Forms in a Health Record (HREC)
081-866-0205	File Authorized Forms in an Outpatient Treatment Record (OTR)
081-866-0206	File Authorized Forms in an Inpatient Treatment Record (ITR)
081-866-0207	File Authorized Forms in an Ambulatory Procedure Visit (APV) Record.

Academic Hours

The Academic hours required to teach this TSP are as follows:

	ADT Hours/Methods
	4.0 / Conference / Discussion
Test	0.0 /
Test Review	0.0 /
Total Hours:	4.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
None	

Clearance Access

Security Level : Unclassified
Requirements : There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
MCHO-CL-P (40)	MEDCOM Memorandum	16 Oct 1997	
AR 40-66	Medical Record Administration (20 Jul 92)	01 Jan 1900	
DA Form 8005	Outpatient Medical Record (OMR) Orange	01 Jan 1900	
DA Form 3444-Series	Terminal Digit File for Treatment Record	01 Jan 1900	

Student Study Assignments

None

Instructor Requirements

One (1) MOS 71G Qualified Instructor

Additional Personnel Requirements

None

Equipment Required for Instruction

Name	Quantity	Expendable
Screen, Projector	0	No
Projector, Still, 35mm	0	No

Materials Required

Instructor Materials:
Pointer
35mm slide projector, hand control, and screen
Slides S HPABG023 01-22

Student Materials:
Student handout "Medical Records II Student Handout", M HPABG023 01.

Classroom, Training Area, and Range Requirements

CLASSROOM LABORATORY EQUIPPED 44PER

Ammunition Requirements

Name	Student Qty	Misc Qty
None		

Instructional Guidance

NOTE: Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material.

The Instructor should distribute student handouts prior to the start of classroom presentation.

Proponent Lesson Plan Approvals	**Name**	**Rank**	**Position**	**Date**

SECTION II. **INTRODUCTION**

Method of Instruction: Conference / Discussion

Instructor to Student Ratio is: 1:45
Time of Instruction: 4 hrs
Media: PRINT

Motivator

Filing is a tedious task, but a necessary one. Your dedication to the proper filing of medical forms is a part of the health maintenance of patients. Proper operation of medical records is very important to health and well being of the patient.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	File authorized forms in Army Medical Records.
Conditions:	Given a list of medical forms, AR 40-66, Medical Record Administration, DA Form 3444-Series Folder and DA Form 8005-Series Folder.
Standards:	The soldier must file authorized forms in Army Medical Records IAW MEDCOM MEMO MCHO-CL-C (40).

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Medical records may be considered a precise technology; one that requires specialized knowledge for the exact maintenance of records for the medical well being of patients. They are not only a place to store data and information on the patients, they are a tool that medical professionals must use to determine current and historical medical histories on the patient. To maintain and operate medical records efficiently, the Patient Administration Specialist must understand every aspect of this tool, especially the proper filing of forms and documents to form the medical record.

Slide S HPABG023 01: Medical Records II

SECTION III. PRESENTATION

A. ENABLING LEARNING OBJECTIVE A

ACTION:	File authorized forms in a Health Record (HREC).
CONDITIONS:	Given a list of medical forms, AR 40-66, and DA Form 8005-Series Folder.
STANDARDS:	The soldier must file authorized forms in a HREC IAW AR 40-66.

1. Learning Step / Activity 1. Filing forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 02: Medical Records II: Filing Forms

a. Forms will be filed from top to bottom in a prescribed order, to make access easier,.
b. Copies of identical forms are to be grouped and filed in reverse chronological order with the most recent form on the top.
c. National Guard (NG) and US Army Reserve (USAR) members on active duty training will be marked "ADT" on the front of the file folder and on the lower margin each form filed within the folder.

Slide S HPABG023 03: Medical Records II: Filing Forms

NOTE: Folders for NG and USAR members will be maintained in the same manner as those for other active duty members.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Forms to be filed on the left side of the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

NOTE: (*)Entries indicate forms that will be prepared when a HREC is initiated.

Slide S HPABG023 03A: Medical Records II: Filing Forms

a. DA Forms 3180, 3180A: Personnel Screening and Evaluation Record (if applicable).
*b. DA Form 5571: Master Problem List.
*c. SF 601: Immunization Record.
*d. SF 545: Laboratory Report Display.
*e. SF 519 & 519A: Radiographic Report.

Slide S HPABG023 03B: Medical Records II: Filing Forms

f. DA Form 3647-1: Inpatient Treatment Record Coversheet copy.
g. SF 502: Narrative Summary copy.

NOTE: The following form is preprinted in the terminal digit file folders.

h. DA Form 4410-R: Disclosure Accounting Record.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Forms to be filed on the right side of the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

NOTE: (*)Entries indicate forms that will be prepared when a HREC is initiated.

Slide S HPABG023 03C: Medical Records II: Filing Forms

a. DA Form 4515: Personnel Reliability Program Record Identifier (if applicable).
*b. SF 600: Chronological Record of Medical Care (key form used to record patient care).
*c. SF 558: Medical Record -Emergency Care and Treatment.
*d. DA Form 5181-R: Screening Note of Acute Medical Care (will be filed here if used in place of SF 600).

Slide S HPABG023 03D: Medical Records II: Filing Forms

e. State ambulance forms: used to record ambulance (pre-hospital) treatment.
f. DA Form 3349: Physical Profile.
g. DA Form 3947: Medical Evaluation Board Proceedings.
*h. SF 88: Report of Medical Examination (original).

Slide S HPABG023 03E: Medical Records II: Filing Forms

*i. SF 93: Report of Medical History (original).
j. SF 513: Medical Record--(consultation sheet).
k. Living Will: an administrative document that may be filed in the HREC.

Slide S HPABG023 03F: Medical Records II: Filing Forms

NOTE: The following form is pre-printed in the terminal digit file folders.

*l. DD Form 2005: Privacy Act Statement (signed by the patient).

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	File authorized forms in an Outpatient Treatment Record (OTR).
CONDITIONS:	Given a list of medical forms, AR 40-66, and DA Form 8005-Series Folder.
STANDARDS:	The soldier must file authorized forms in an OTR IAW AR 40-66.

1. Learning Step / Activity 1. Determine if the form is authorized.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 04: Medical Records II: Authorized Forms

a. Check the form title and reference number.
b. Refer to AR 40-66 and compare the form title and number to the list of authorized forms.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. File the form in the proper location in the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 05: Medical Records II: Forms Location

a. Check the patient identifier fields of the form for complete and correct information against the labeling on the folder.
b. Determine in which section of the folder to file the form.
(1) Check the form name and reference number.
(2) Refer to the AR 40-66 for the location in which to file the form.
(3) File the form in the proper location.

Slide S HPABG023 06: Medical Records II: Forms Location

NOTE: Forms should be filed in a location as specified in the AR 40-66. If forms are of the same form type (not copies), they should be filed chronologically with the most recent dated one on top.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	File authorized forms in an Inpatient Treatment Record (ITR).
CONDITIONS:	Given a list of medical forms, AR 40-66, and DA Form 3444-Series Folder.
STANDARDS:	The soldier must file authorized forms in an ITR IAW AR 40-66.

1. Learning Step / Activity 1. Determine if the form is authorized.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 07: Medical Records II: Authorized Forms

a. Check the form title and reference number.
b. Refer to AR 40-66 and compare the form title and number to the list of authorized forms.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. File the form in the proper location in the folder.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 08: Medical Records II: Forms Location

a. Check the patient identifier fields of the form for complete and correct information against the labeling on the folder.
b. Determine in which section of the folder to file the form.
(1) Check the form name and reference number.
(2) Refer to the AR 40-66 for the location in which to file the form.
(3) File the form in the proper location.

Slide S HPABG023 09: Medical Records II: Forms Location

NOTE: Forms should be filed in a location as specified in the AR 40-66. If forms are of the same form type (not copies), they should be filed chronologically with the most recent dated one on top.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

D. ENABLING LEARNING OBJECTIVE D

ACTION:	File authorized forms in an Ambulatory Procedure Visit (APV) record.
CONDITIONS:	Given a list of medical forms, AR 40-66, and DA Form 3444-Series Folder
STANDARDS:	The soldier must file authorized forms in an APV record IAW AR 40-66.

1. Learning Step / Activity 1. Determine the appropriate forms to be filed in the APV record.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 10: Medical Records II: APV

NOTE: The APV Record will not be Carded For Record Only. All documentation will be filed in a properly prepared DA 3444 series folder.

Slide S HPABG023 11: Medical Records II: APV

a. Determine the forms tile and reference number.
b. Determine if the forms are authorized for filing in an APV Record, in accordance with MEDCOM memorandum, MCHO-CL-C: Ambulatory Procedure Visit (APV), para. 5-g-(a).

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. File the authorized forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG023 12: Medical Records II: APV

a. Forward a copy of the patient's post-procedure instructions, with a summary of care, e.g., SF 509 or SF 539, etc. to the health/outpatient treatment record.

NOTE: A control procedure should be initiated to ensure that the APV is annotated on the Master Problem List (DA Form 5571).

Slide S HPABG023 13: Medical Records II: APV

NOTE: An internal procedure for tracking the APV is to be developed by the MTF.

Slide S HPABG023 14: Medical Records II: APV

b. File all documentation related to the APV in a DA Form 3444-series folder or DA Form 8005-series folder, on the left side of the inpatient folder.

c. Store APV records in a limited access area of the MTF.

Slide S HPABG023 15: Medical Records II: APV

NOTE: Do not integrate the original APV record into the health/outpatient treatment record.

Slide S HPABG023 16: Medical Records II: APV

NOTE: APV records may be retired to the National Personnel Records Center IAW AR 25-400-2 five (5) years after the end of the year of the last inpatient disposition or APV. Army MEDDACs retire records 1 year after the end of the year of the last inpatient disposition or APV.

Slide S HPABG023 17: Medical Records II: APV

d. Forward a copy of the patient's post-procedure instructions, with a summary of care, e.g., SF 509 or SF 539, etc. to the health/outpatient treatment record.

Slide S HPABG023 18: Medical Records II: APV

NOTE: A control procedure should be initiated to ensure that the APV is annotated on the Master Problem List (DA Form 5571).

Slide S HPABG023 19: Medical Records II: APV

e. File all documentation related to the APV in a DA Form 3444-series folder or DA Form 8005-series folder, on the left side of the inpatient folder.

Slide S HPABG023 20: Medical Records II: APV

NOTE: An internal procedure for tracking the APV is to be developed by the MTF.

g. Store APV records in a limited access area of the MTF.

Slide S HPABG023 21: Medical Records II: APV

NOTE: Do not integrate the original APV record into the health/outpatient treatment record.

Slide S HPABG023 22: Medical Records II: APV

NOTE: APV records may be retired to the National Personnel Records Center IAW AR 25-400-2 five (5) years after the end of the year of the last inpatient disposition or APV. Army MEDDACs retire records 1 year after the end of the year of the last inpatient disposition or APV.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. **SUMMARY**

Method of Instruction: Conference / Discussion

Instructor to Student Ratio is: 1:45
Time of Instruction: 0 hrs
Media: PRINT

Review / Summarize Lesson

During this lesson we discussed some of the important aspects maintaining medical records. Various types of records were addressed, and the importance of proper record arrangement was emphasized. How and where to file forms and documents for the different types of records was discussed.

Check on Learning

Conduct a check on learning and summarize the lesson.

QUESTION: How are forms of the same type filed in the medical record?
ANSWER: On the designated side, in the proper location, and chronologically.

QUESTION: Are forms filed top to bottom or bottom to top?
ANSWER: Top to bottom.

QUESTION: What is the primary reference for filing medical record forms?
ANSWER: Medical Record Administration (AR 40-66)

QUESTION: In what type of a record is the APV filed?

ANSWER: Inpatient Treatment Record.

SECTION V. STUDENT EVALUATION

NOTE: Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.

Testing Requirements

A written test (50 multi-choice and/or true/false questions) shall be administered testing knowledge of the lessons "Medical Records II" and "Medical Records Management". The student must score a minimum of 70 points to obtain a passing grade.

NOTE: Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

Feedback Requirement

PRACTICAL EXERCISE SHEET PE HPABG023 01

Title

Medical Records II: File Forms in a Health Record (HREC).

Lesson Number/Title

HPABG023 version 1 / Medical Records II

Introduction

Motivator

Filing is a tedious task, but a necessary one. Your dedication to the proper filing of medical forms is a part of the health maintenance of patients. Proper operation of medical records is very important to health and well being of the patient.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	File authorized forms in Army Medical Records.
Conditions:	Given a list of medical forms, AR 40-66, Medical Record Administration, DA Form 3444-Series Folder and DA Form 8005-Series Folder.
Standards:	The soldier must file authorized forms in Army Medical Records IAW MEDCOM MEMO MCHO-CL-C (40).

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Medical records may be considered a precise technology; one that requires specialized knowledge for the exact maintenance of records for the medical well being of patients. They are not only a place to store data and information on the patients, they are a tool that medical professionals must use to determine current and historical medical histories on the patient. To maintain and operate medical records efficiently, the Patient Administration Specialist must understand every aspect of this tool, especially the proper filing of forms and documents to form the medical record.

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
35mm slide projector, hand control, and screen

Student Materials:
Student handout "Medical Records II Student Handout" , M HPABG023 01.

Special Instructions

Procedures

Below is a list of forms that are normally filed in a Health Record, DA Form 3444-Series. Using the letter L to indicate left side of the record and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ SF 601, Immunization Record.

2. _____ DA Form 3947, Medical Evaluation Board Proceedings.

3. _____ DA Form 2631-R, Medical Care--Third Party Liability Notification.

4. _____ SF 600, Chronological Record of Medical Care.

5. _____ DD Form 2005, Privacy Act Statement.

6. _____ DA Form 3349, Physical Profile.

7. _____ SF 88, Report of Medical Examination.

8. _____ SF 93, Report of Medical History.

9. _____ SF 560, Medical Record; Electroencephalogram Request and History.

10. _____ DA Form 4515, Personnel Reliability Program Identifier.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 1

Below is a list of forms that are normally filed in a Health Record, DA Form 3444-Series. Using the letter L to indicate left side of the record and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ SF 601, Immunization Record.

2. _____ DA Form 3947, Medical Evaluation Board Proceedings.

3. _____ DA Form 2631-R, Medical Care--Third Party Liability Notification.

4. _____ SF 600, Chronological Record of Medical Care.

5. _____ DD Form 2005, Privacy Act Statement.

6. _____ DA Form 3349, Physical Profile.

7. _____ SF 88, Report of Medical Examination.

8. _____ SF 93, Report of Medical History.

9. _____ SF 560, Medical Record; Electroencephalogram Request and History.

10. _____ DA Form 4515, Personnel Reliability Program Identifier.

PRACTICAL EXERCISE SHEET PE HPABG023 02

Title

Medical Records II: File Forms in an Outpatient Treatment Record (OTR).

Lesson Number/Title

HPABG023 version 1 / Medical Records II

Introduction

Motivator

Filing is a tedious task, but a necessary one. Your dedication to the proper filing of medical forms is a part of the health maintenance of patients. Proper operation of medical records is very important to health and well being of the patient.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	File authorized forms in Army Medical Records.
Conditions:	Given a list of medical forms, AR 40-66, Medical Record Administration, DA Form 3444-Series Folder and DA Form 8005-Series Folder.
Standards:	The soldier must file authorized forms in Army Medical Records IAW MEDCOM MEMO MCHO-CL-C (40).

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Medical records may be considered a precise technology; one that requires specialized knowledge for the exact maintenance of records for the medical well being of patients. They are not only a place to store data and information on the patients, they are a tool that medical professionals must use to determine current and historical medical histories on the patient. To maintain and operate medical records efficiently, the Patient Administration Specialist must understand every aspect of this tool, especially the proper filing of forms and documents to form the medical record.

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
35mm slide projector, hand control, and screen

Student Materials:
Student handout "Medical Records II Student Handout", M HPABG023 01.

Special Instructions

Procedures

Below is a list of forms that are normally filed in an Outpatient Treatment Record, DA Form 3444-Series. Using the letter L to indicate left side of the folder and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ SF 560, Electroencephalogram Request and History.

2. _____ DA Form 3180-A, Personnel Screening and Evaluation Record.

3. _____ DA Form 5571, Master Problem List.

4. _____ SF 519, Radiographic Report Display.

5. _____ SF 545, Laboratory Report Display.

6. _____ DA Form 3365, Authorization Medical Warning Tag.

7. _____ SF 600, Chronological Record of Medical Care.

8. _____ DD Form 2005 Privacy Act Statement.

9. _____ SF 600 Chronological Record Medical Care.

10. _____ DD Form 4410-R, Disclosure Accounting Record.

Feedback

Requirements	

SOLUTION FOR
PRACTICAL EXERCISE SHEET 2

Below is a list of forms that are normally filed in an Outpatient Treatment Record, DA Form 3444-Series. Using the letter L to indicate left side of the folder and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ SF 560, Electroencephalogram Request and History.

2. _____ DA Form 3180-A, Personnel Screening and Evaluation Record.

3. _____ DA Form 5571, Master Problem List.

4. _____ SF 519, Radiographic Report Display.

5. _____ SF 545, Laboratory Report Display.

6. _____ DA Form 3365, Authorization Medical Warning Tag.

7. _____ SF 600, Chronological Record of Medical Care.

8. _____ DD Form 2005 Privacy Act Statement.

9. _____ SF 600 Chronological Record Medical Care.

10. _____ DD Form 4410-R, Disclosure Accounting Record.

PRACTICAL EXERCISE SHEET PE HPABG023 03

Title

Medical Records II: File Forms in an Inpatient Treatment Record (ITR).

Lesson Number/Title

HPABG023 version 1 / Medical Records II

Introduction

Motivator

Filing is a tedious task, but a necessary one. Your dedication to the proper filing of medical forms is a part of the health maintenance of patients. Proper operation of medical records is very important to health and well being of the patient.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	File authorized forms in Army Medical Records.
Conditions:	Given a list of medical forms, AR 40-66, Medical Record Administration, DA Form 3444-Series Folder and DA Form 8005-Series Folder.
Standards:	The soldier must file authorized forms in Army Medical Records IAW MEDCOM MEMO MCHO-CL-C (40).

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Medical records may be considered a precise technology; one that requires specialized knowledge for the exact maintenance of records for the medical well being of patients. They are not only a place to store data and information on the patients, they are a tool that medical professionals must use to determine current and historical medical histories on the patient. To maintain and operate medical records efficiently, the Patient Administration Specialist must understand every aspect of this tool, especially the proper filing of forms and documents to form the medical record.

Resource Requirements

Instructor Materials:
Chalkboard
Chalk
Eraser
Pointer
35mm slide projector, hand control, and screen

Student Materials:
Student handout "Medical Records II Student Handout", M HPABG023 01.

Special Instructions

Procedures

Below is a list of forms that are normally filed in a Inpatient Treatment Record, DA Form 3444-Series. Using the letter L to indicate left side of the folder and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ DA Form 4515, Personnel Reliability Program Record Identifier.

2. _____ DA Form 5179, Medical Record--Preoperative/Postoperative Nursing Document.

3. _____ DA Form 3647-1, Inpatient Treatment Record Cover Sheet.

4. _____ DA Form 3888, Nursing Assessment and Care Plan.

5. _____ DA Form 3947, Medical Evaluation Board Proceedings.

6. _____ DA Form 2984, Very Seriously Ill/Seriously Ill/Special Category Patient Report.

7. _____ DA Form 2631-R, Medical Care-Third Party Liability Notification.

8. _____ Administrative documents and other correspondence.

9. _____ SF 506, Clinical Record--Physical Examination.

10. _____ SF 516, Medical Report--Operation Report.

Feedback Requirements	

SOLUTION FOR
PRACTICAL EXERCISE SHEET 3

Below is a list of forms that are normally filed in a Inpatient Treatment Record, DA Form 3444-Series. Using the letter L to indicate left side of the folder and R to indicate the right side, write the side of the folder on which each form is to be filed. The forms are listed in the AR 40-66.

1. _____ DA Form 4515, Personnel Reliability Program Record Identifier.

2. _____ DA Form 5179, Medical Record--Preoperative/Postoperative Nursing Document.

3. _____ DA Form 3647-1, Inpatient Treatment Record Cover Sheet.

4. _____ DA Form 3888, Nursing Assessment and Care Plan.

5. _____ DA Form 3947, Medical Evaluation Board Proceedings.

6. _____ DA Form 2984, Very Seriously Ill/Seriously Ill/Special Category Patient Report.

7. _____ DA Form 2631-R, Medical Care-Third Party Liability Notification.

8. _____ Administrative documents and other correspondence.

9. _____ SF 506, Clinical Record--Physical Examination.

10. _____ SF 516, Medical Report--Operation Report.

2. *Medical Histories*

An important component of a patient's medical record is his or her medical history. An important of the reengineered Military Health System is a standardized data system used within each branch of the military and by all of the branches. To reach the goal of standardized data and information capture, maintenance, and management, all personnel recording medical histories will need to ask the same questions and record answers using standardized abbreviations and forms.

This section D.2. includes procedures, training materials, forms, and abbreviations developed by the Air Force for interviewing patients and recording their medical histories. Although the Air Force created the materials, they are easily converted to other branches of the armed forces.

Recording Medical Histories, An Overview

INTERVIEWING GOALS

A. History Taking

1. Reviewing the Basics
   - Review the patient's medical record prior to interviewing the patient. (Note: You should be doing this anyway as part of preventive services.)
   - Review factors in the history taking process

2. Setting
   - Insure patient comfort, and be sure the patient is seated at eye level with the interviewer.
   - The patient gets your FULL attention; avoid interruptions.
   - Protect the patient's privacy, safety, and modesty. This is a MUST.

3. Be a good communicator. Work on skills that show interest, attention, acceptance, and understanding such as:
   - Eye contact with the patient
   - Your posture
   - Gestures you make
   - The words you use
   - DO NOT express negative reactions to patient information

4. Questioning
   - Help guide the patient using:
     a. Facilitation ("Mm-hmm, Go on")
     b. Reflection (Repeating what the patient says encourages the patient go provide more detail.)
     c. Clarification ("Tell me what you meant by…")
   - Ask direct questions; go from general to specific questions
   - Develop the attributes of symptoms using the **O,P,Q,R,S,T** method
   - AVOID asking leading questions

5. Structure of the Interview
   - First conduct a step-by-step evaluation of why the patient is here.
   - Then explore the patient's concern(s).
   - The most common method is a chronological account of concerns, events, disease, etc.
   - LISTEN TO THE PATIENT!

6. Documenting
   - Problem Oriented (Short)

- SOAPP Notes

  The SOAPP note is the standard format used to record patient progress notes in an outpatient setting. The acronym refers to:
  S = SUBJECTIVE
  O = OBJECTIVE
  A = ASSESSMENT
  P = PLAN
  P = PREVENTION
  S = SUBJECTIVE
- This is basically what the patient tells you and is your primary area of concern when recording information for the provider.
- Subjective information includes (suggested structure):
  a. Patient Identification
  b. Chief Complaint (c/c)
  c. History of Present Illness (HPI) "OPQRST"
  d. Associated Symptoms
  e. Current Meds
  f. Allergies
  g. Pertinent Social History

B. SOAPP Notes

1. S=SUBJECTIVE
   - Patient Identification: Age, sex, race, occupation, status
     Example: 18 y/o WM ADAF Med tech
   - Chief Complaint: If possible, in patient's own words
     Example 1: presents with "I have a painful click in my knee."
     Example 2: presents with c/o L Knee pain x 3 days
   - History of Present Illness (HPI) - This is where we begin to develop the Symptom Attributes to fill in the details. A common method is using "**OPQRST**":

     O: Onset (When/How did it start?)
     P: Provocative/Palliative (What makes it better/worse?)
     Q: Quality (Sharp, dull, aching, throbbing?)
     R: Region/Radiation (Where is it, does it radiate?)
     S: Severity/Strength (Scale of 1-10? compared to? Any limitations?)
     T: Time/Treatment (Had before? When? Compare then and now? Duration? Treatment - if meds include exact dose/frequency, relief from treatment?)

   - While we realize that "OPQRST" may not exactly apply to every patient presentation, it is certainly a good starting point when beginning interviews.

- HPI may also include pertinent questions about past medical history, immunizations, habits, hobbies, religious preference, living conditions, finances, exposures, family history, or other associated symptoms based on the suspected systems that are involved. This will become more familiar to you with extended experience.
- Other appropriate questions for female patients with potential OB/GYN disorders:
    a. Gravida/Para?
    b. Last Normal Menstrual Period (LNMP)?
    c. Sexual Activity?
    d. Method of Birth Control (including problems i.e. missed pills)
    e. Current Medications (May already be noted in HPI); Include dosage/frequency/relief or effectiveness, and ask about preparations commonly not considered meds such as aspirin, vitamins, and birth control pills.
    f. Allergies: drugs, insects, food, other?
- Pertinent Social History - Remember the Stages of Change and appropriate intervention counseling techniques.
    a. *Tobacco* - (smoke, dip or chew) frequency/quantity?
    b. *Alcohol* – type/frequency/quantity?
    c. *Life style* - diet, exercise?

2. O = OBJECTIVE
- This is what is observed in the patient by medical personnel and includes:
    a. Vital Signs
    b. General Impression
    c. Physical Exam
    d. Results of any same day procedures/lab tests
- The majority of Objective information comes from the provider. However, you provide vital sign information and may be called upon to provide the general impression. Example: 28 y/o well developed, well nourished, black male, oriented and in no acute distress
- Skilled Technician Support
    a. Knowing the involved systems (and your provider approach), you will be responsible to insure the patient is appropriately prepared for the physical exam and that all materials needed for the exam (instruments, supplies) are pre-positioned so as to expedite the process.
    b. Remember that at all times but especially at this point in the process, you must continuously keep the patient informed of any delays in seeing the provider. THIS IS AN EXTREMELY IMPORTANT COURTESY THAT MUST NOT BE OVERLOOKED!

c. You will also assist the provider with the exam and any special procedures and will come to realize this can be a great learning experience.

d. Again, clinicians will differ in their approach and some adaptation is expected, but you are now on your way to becoming a truly cohesive "Provider/Technician Team" that provides thorough, skillful care in a minimum amount of time.

3. A = ASSESSMENT

Based on the Subjective and Objective information, this is the provider's evaluation of what is going on with the patient. It may be a single diagnosis or a list of several probable diagnoses. As we mentioned earlier, if there is a list of probable diagnoses, then the Plan (P) will include further procedures or tests to help confirm or "rule out" some of the suspected causes of the patient's problem.

4. P = PLAN

This is the providers plan of care for the patient and generally includes:

- The actual treatment mechanism
- Meds (strength, dose, frequency, ROA, #given, refills)
- Therapy
- Crutches
- Other
- Further Testing (Lab, X-ray, ECG, etc.)
- Admin Support (Sick Slip, Profile, PRP recommendation)
- Patient Instructions (DOs/DON'Ts)
- Expectation of wellness
- Follow-up instructions

5. P = PREVENTION COUNSELING

This is done during every patient visit and is where we formally document advice given to the patient about high-risk behaviors identified during this visit and also for official referrals for further education from community based services. Example: HAWC. It is done in addition to addressing preventive health topics on DD Form 2766 as part of a PHA or HEAR evaluation. To assist you in performing this task (counseling), you will be given further training in counseling techniques for lifestyle risk factor reduction.

C. Verbal Communication With Providers

As a PCM technician, you will need to become very proficient at not only writing, but also speaking in terminology that communicates to your provider the patient's history. It is not necessary to read to the provider what you have written. You do, however, need to quickly give a synopsis of the pertinent positives and negatives from the interview.

This informal report must be organized in a format acceptable to your provider and must effectively relay the patient's presentation. Again, no two providers will want the same presentation and you will probably find that some variation is a beneficial learning experience.

You are not expected to be an expert immediately, as this skill takes time and experience to fully develop. With self-study and practice however, you will soon build a working relationship that runs like "clockwork".

D. Legal Considerations

To complete this lesson it is important that we discuss risk management considerations. Your behavior during the entire episode of care must remain above reproach. Specifically:

1. <u>During the interview</u>:

- DO NOT express negative reaction to any patient information
- Avoid appearing flippant, non-caring, or combative
- Avoid sexual banter, dirty jokes or crude language (unless this is the only thing the patient will understand)
- Ensure privacy and safety at all times

2. <u>During the Physical Exam</u> (with your provider):

- Keep the patient advised of any delays
- Ensure safety and privacy at all times
- Always chaperone when appropriate
- Explain what is being done and why, ensure the patient understands
- Give honest answers (to include "I don't know, but we'll find out") when the patient ask for information
- Know your job! Always demonstrate that you are a professional, and a key member of the healthcare team.

3. <u>In the Medical Record</u>:
You must be aware that anything written in the healthcare record has the potential to become legal evidence in a court of law.
Some Documentation Tips:
- Anytime you write in a medical record insure the complete patient ID information is on the form you are writing on (not writing in John Junior's record when your caring for John Senior)
- Write neatly and legibly in blue/black ink - A MUST!

- DO NOT write editorial comments or opinions; be like Joe Friday (Dragnet) "Just the Facts"
- DO NOT alter a medical record (even coffee stains). Errors are struck through with a single line, initialed and dated.
- Your provider should always document any follow-up instructions given to the patient.

E. Sample Technician Entry

S - 18 y/o WM, ADAF Amn, personnel tech, c/o "my L knee hurts" x 3 days. Playing basketball, jumped to shoot, upon landing twisted knee with immediate pain/swelling. Used ice/rest but continued pain, worse with activity (standing, marching, running), better with rest. Pain located laterally, throbbing, without radiation. No popping/locking but unstable with lateral movement. No Hx of knee injury, No significant PMH, NKDA. Meds - Advil 200mg, 2 tabs BID x 2 days with some relief. SH - denies tobacco or ETOH use

O - VS: BP 110/80 R12 P80 T97.6, Gen Imp: Well male in NAD, ambulates with limp

PLAN OF INSTRUCTION - LESSON PLAN (PART I)

COURSE TITLE	TIME
Aeromedical Apprentice (B3ABY4F0X1-001)	8 / 0

BLOCK TITLE	BLOCK NUMBER
Physical Exams	VII

UNIT TITLE	UNIT NUMBER
Recording a Medical History (SF 93)	12

STS REFERENCE	MEASUREMENT	PROFICIENCY CODE
13b, 13c(2)	2b	W / P

OBJECTIVE: Given a problem case scenario and an SF 93, elicit a complete medical history IAW AFI 48-133.

SAMPLES OF BEHAVIOR
1. Identify terms associated with eliciting a medical history.
2. Explain procedures for completing the SF 93.
3. Describe the technique and procedure for soliciting a medical history.
4. Describe the two types of medical histories.

SUPPORT MATERIAL AND GUIDANCE

STUDENT REFERENCES:
Aeromedical Apprentice Student Handout
AFP 48-133
AFI 48-123

TRAINING EQUIPMENT: Audiovisual Projection Unit

AUDIOVISUAL AIDS: Projection Media

TRAINING METHODS: Lecture (2 hours) and Demonstration / Performance (6 hours)

INSTRUCTOR GUIDANCE:
This unit of instruction will be divided into two sections. In Section One, the instructor will deliver a two-hour informal lecture utilizing various questioning techniques to foster student interaction in the lecture. Section Two will consist of 3-two hour lab rotations. The students will be given problem cases to work out. Try to have the students accomplish at least two problem cases per rotation. Review the problem cases and give the students ideas on how they

can improve their medical histories. Following the lecture and the rotations, the students should have a very good understanding of the art of history taking.

INSTRUCTOR REFERENCES:
AFP 48-133
AFI 48-123

ADDITIONAL INSTRUCTOR REQUIREMENTS: None

PART II - TEACHING GUIDE

I. COURSE NUMBER AND TITLE: B3ABY4F031-001, Aeromedical Apprentice

II. SUBJECT: Physical Examination Techniques and Procedures

III. LESSON: Recording a Medical History

IV. TIME REQUIRED: 2 Hours

V. INSTRUCTOR:

VI. INTRODUCTION:

A. Attention:

B. Motivation:

C. Lesson Objective: Given a problem case scenario and an SF 93, elicit a complete medical history. IAW AFI 48-133.

D. Overview:

1. Identify terms associated with eliciting a medical history.
2. Explain procedures for completing the SF 93.
3. Describe the technique and procedure for soliciting a medical history.
4. Describe the two types of medical histories.

E. Transition:

VII. DEVELOPMENT:

A. Definitions:

1. **Childhood** - if an item of medical history occurred when the examinee was age 11 or younger, it occurred in childhood

2. **NCNS** - no complications, no sequela
   a. Complications - refers to a disease condition concurrent with another disease

   b. Sequela - a condition following or occurring as a result of another condition or event

3. **Complete medical history -** any medical history from childhood to present

a. Must be accomplished for the following:

1. Enlistment or Commission in the AF active duty or its Reserves

2. On all ARC member physical exams IAW AFI 48-123

3. Whenever the examining physician requests

b. Must be brought forward with each PHA or

1. Periodic flying and non-flying examinations

2. Whenever an examination is sent for higher authority review

4. **Interval medical history -** only significant items of medical history since the last examination are recorded and added to the end of the complete medical history

B. Completion of SF 93 by Examinee

1. Examinee **must** complete the SF 93 in one copy

2. Items 1 through 7 may be typewritten (same format as items on SF 88)

3. Item 8 (Must be in examinee's handwriting)

a. Short statement of examinee's present health

b. List any current medication

4. Items 9 and 10 - examinee will place an "X" in the appropriate yes or no block

5. Item 11 - examinee will place an "X" in the appropriate yes, no, or don't know block

6. Item 12 - for female examinee's only - male examinee's enter N/A

7. Item 13 - self explanatory (examinee's handwriting)

8. Item 14 - self explanatory (examinee's handwriting)

9. Item 15 - 24 (examinee's handwriting)

a. Must check appropriate block

b. Must explain affirmative checks in the blank space to the right of the questions preceded by the item reference number

10. Signature - have the examinee read the statement above the signature block, then print and sign their name

C. Soliciting and Writing a Medical History

1. Always done in a private place

2. Recorded first in a rough draft

3. Must have dates - final is in chronological order (childhood to present)

4. **ALL** affirmative and "don't know" check marks must be explained to the technician by the examinee

D. Writing the Medical History

1. **First step - Ask...**

a. Did you have any *childhood diseases*?

b. Did you have any *operations as a child*? If so, what were they for?

c. Do you have any *scars* from injuries suffered in childhood that are one inch in length or longer?

2. **Second step - Review the SF 93...**

a. *Item 8* - if health is less than good or on medications a comment must be made

b. *Items 9 and 10* - record the necessary information for any item answered affirmatively (**except** for block 10, item 2)

c. *Items 11 and 12* - record the necessary information for any item answered affirmatively (also includes "don't know responses)

d. *Items 15 through 24* - elaborate further

3. **Third step - Ask...**

a. Is there a history of *diabetes* in yourself or your family (parent, sibling, or more than one grandparent)?

b. Is there a history of *psychosis* (mental illness) in yourself or in your family (parent or sibling)?

c. Do you now or have you ever worn *contact lenses*?

d. Have you ever had *irradiation therapy*?

e. Have you ever experienced motion sickness or a *disturbance of consciousness*?

f. Are there *any other items* of medical or surgical history that you have not mentioned?

E. Recording the Medical History

1. History is typed in item #25 on SF 93 in the following order:

a. Common childhood diseases

b. Operations in childhood

c. Significant traumatic scars form childhood injuries

d. Items from the SF 93 in chronological order

e. List any affirmative answers from "third step"

(1) If all questions were negative responses, record the long denial statement

(2) If there are affirmative responses to any of the questions, omit the corresponding phrase from the denial statement

2. **LONG DENIAL STATEMENT** - Examinee denies personal or family history of diabetes or psychosis, use of contact lenses, history of motion sickness or disturbances of consciousness, irradiation therapy and all other significant medical or surgical history

F. Interval Medical History

1. Accomplished when a complete history is already on file

2. Significant items of medical history recorded

a. Required hospitalization

b. Required excusal, grounding, profile change or suspension from flying status

c. Do not record "routine" items such as URIs, viral illnesses, etc., unless hospitalization was required, the illness is of a frequent or chronic nature, or it precluded flying

3. Obtaining information

a. Ask the examinee

b. Review the medical records

c. Use SF 93 as a guide

4. Record in chronological order - same way as complete medical history (diagnosis, date, cause, treatment, recovery, complications, sequela)

5. Recorded on most current SF 93 using the SF 507 when additional space is needed.

6. **SHORT DENIAL STATEMENT** - "No other significant medical or surgical history to report since last examination (enter the date of that examination in parentheses)

7. If no interval medical history replace the words "other significant" with "interval"

VIII. CONCLUSION:

A. Summary:

1. Definitions

a. Childhood - age 11 or younger

b. NCNS

c. Interval medical history

d. Complete medical history - when accomplished

2. Completion of SF 93 by examinee

3. Soliciting and writing a medical history

4. Procedures for writing a medical history

5. Recording the complete medical history

6. Recording the interval medical history

B. Remotivation:

C. Closure:

Volume 4 Module 2

OBTAIN AND RECORD MEDICAL HISTORY

SUBJECT AREA: Nursing Care in the Outpatient Clinic

TASK NAMES: History and physical; Obtain and record medical histories

EQUIPMENT REQUIRED:

1. SF 600, blue/black ink pen and patient scenario
2. References as determined necessary by the individual being evaluated

TRAINING REFERENCES: Guide to Physical Examination

OBJECTIVE: Provided a patient, medical records, and clinical setting, obtain and record the problem-oriented history (S portion of the SOAPP note) using the SOAPP format

EVALUATION INSTRUCTIONS:
Insure the trainee has completed the read-ahead module (attachment 5) prior to classroom lecture. Conduct lecture using lesson plan (attachment 2) and slide set (attachment 6).
After the trainee has received instruction allow sufficient practice on each part of the task.
Use the performance checklist (attachment 1) to ensure all steps of the task are accomplished.
Trainees may role-play using locally developed or provided scenarios (attachment 3) and common terms (attachment 4).
Document task competency upon completion of the evaluation in the trainee's OJT record.
Initial evaluation should be documented on the USAFE Command AF 797. All recurring evaluations should be documented on AF Form 1098.

NOTE: The evaluator will **STOP** the procedure immediately and correct the trainee if performance is detrimental to patient safety.

STEPS IN TASK PERFORMANCE:

1. Obtain patient history
2. Document history and physical in SOAPP format

ATTACHMENTS: 1. Performance checklist (QTP)
2. Lesson Plan
3. Patient History Scenarios
4. Common Terms
5. Read Ahead Module
6. Lesson Plan Slide Set

VOL 4 MODULE 2 OBTAIN AND RECORD MEDICAL HISTORY: **Attachment 1**

PERFORMANCE ITEM	SAT	UNSAT

PERFORMANCE ITEM	SAT	UNSAT
1. Obtain patient history a. Chief Complaint (uses patients own words) b. History of present illness 1. O: Onset P: Provocation/Palliation Q: Quality R: Radiation S: Severity T: Timing c. Associated symptoms d. History and habits pertinent to the chief complaint 1. Allergies 2. Medications 3. Previous medical/surgical care 4. Habits: a. Diet b. Sleep c. Alcohol d. Caffeine e. Tobacco f. Substance e. Other problems 3. Document history in SOAPP format a. Subjective history must be in easily understood format and include all pertinent positives and negatives **CRITICAL CRITERIA** Failure to obtain ***Chief Complaint*** Failure to obtain **OPQRST** Failure to obtain patient ***Allergies*** Failure to document significant data in easily understood format		
FINAL RESULT:		

LESSON PLAN **Attachment 2**

MEDICAL HISTORY AND DOCUMENTATION

INTRODUCTION (5 MIN)

ATTENTION:

MOTIVATION:

OVERVIEW:
Provided a patient, medical records, and clinical setting, obtain and record the problem oriented history (S portion of the SOAPP note) using the SOAPP format.

(1) History Taking

(2) SOAPP format

(3) Verbal report

(4) Legal Issues

TRANSITION:

BODY (2 hours)

CONCLUSION (5 MIN)

SUMMARY:

Provided a patient, medical records, and clinical setting, obtain and record the problem oriented history (S portion of the SOAPP note) using the SOAPP format.

(1) Taking a History

(2) SOAPP format

(3) Oral report

(4) Legal issues

REMOTIVATION:

ASSIGNMENT:

CLOSURE:

Patient History Scenarios Attachment 3

Scenario 1
A 22 y.o. male reports to the hospital and complains of chest pain. He states this pain started last PM while lifting weights at the gym. He denies any Hx of trauma He describes pain as "sharp" in nature but is unable to pinpoint the location of the pain. The pain increases with respiration. He also complains of a dry hacking cough. He smokes 1_ packs of cigarettes per day for past 3years. B/P 130/78, T 36.67º C, P 99, R 32

Scenario 2
A 36 y.o. Female TSgt reports to the clinic complaining of cough and shortness of breath. She states that this began about 2 hours while driving back from leave. She smokes 1 PPD. She further states that she was involved in a MVA 14 hrs ago but was checked out at the local hospital and was treated and released. B/P 108/88, T 37.56ºC, P 100. R 26.

Scenario 3
48 y.o. Male, LtCol, your commander, reports to the Clinic with a complaint of right lower leg pain. The pain began two days ago while he was attending a Command conference. The pain seems to be worse today than it had been. He also states that the leg seems to be warm and that his shoe doesn't seem to fit proper. B/P 138/82, T 37.9ºC, P 92, R 18 PE reveals redness over the calf.

Scenario 4
20 y.o. male A1C sent to the clinic by supervisor because he is irritable and has been late three times this week. The Airmen said he was having problems sleeping. He tells you he has had some stomach upset and has wet the bed twice this week. He also complains of severe anal itching especially at night. B/P 124/68, T 37.2ºC, P 68, R 12

Scenario 5
39 y.o Female MSgt reports to the hospital c/o a gnawing, burning abdominal pain x 3 weeks. She says that she is sick of it and "you're the medical folks so fix it and you better fix it quick cause I've got Airmen running around unsupervised at the shop and I need to get back." She states that she has had several episodes of vomiting which seems to decrease the pain for a short time. The pain seems to get worse as the day progresses. She smokes 3 PPD x 10 years and drinks 10 cups of coffee a day. B/P 146/88, T 37.6ºC, P 88, R 20.

Scenario 6
32 y.o. Male SSgt reports to the clinic with complaint of excruciating back pain that goes down into his groin The pain comes and goes. He states that he has had chills with this and says he feels warm now. He also says that he feels the need to urinate frequently. He says that he isn't eating like normal because he feels nauseous. B/P 140/86, T 37.4ºC, P 96, 20

Scenario 7

18 y.o.Male Amn reports to the hospital complaining of burning and blisters to his penis and genital area. He states that it is very painful. He states that his last sexual contact was 4 days ago and that he had multiple partners prior to the last. He does not use condoms. B/P 120/66, T 36.8ºC, P 68, R 16

Attachment 4

Common Terms
When Assisting Providers With Examinations
(O Portion of the SOAPP Note)

HENT EXAM
Symmetrical, without edema, masses, lesions, deformities, tenderness, or lymphadenopathy.
Hair- (*course/fine and) evenly distributed. (*otherwise delete) (note male pattern baldness)
Auricles (or pinna)- symmetrical, without edema, masses, lesions, deformities, tenderness, or,lymphadenopathy.
External ear canals (EAC)- no inflammation or obstruction.
TM's- pearly gray, all landmarks present, move well (or mobile) with valsalva (or insufflation). Note: Do not need mobility tested in adults without complaints.
Weber- equal bilaterally (or without lateralization).
Rinne- AC>BC bilaterally.
No edema, masses, lesions, deformities, or tenderness.
Septum- midline.
Nares- patent.
Turbinates- pink and moist; no edema or exudate.
Sinuses- nontender with palpation and percussion.
Maxillary and Frontal sinuses: transilluminate.
Negative head tilt.
Lips and buccal mucosa- pink and moist; without edema, masses, lesions, deformities, or tenderness
Tongue- midline, without masses, lesions, deformities or tenderness.
Teeth- intact and nontender, no appliances.
Gums- no masses, lesions, deformities, or tenderness.
Tonsils- pink, grade __ , without exudate.

NECK-
Inspection-supple, without edema, masses, lesions, deformities, tenderness, or lymphadenopathy.
Trachea- midline and mobile
Thyroid- unpalpable, no masses or tenderness.

EYES
__/__ OD (R), OS (L); or OU (each eye), uncorrected and corrected (or pinhole if no glasses).
Visual fields by confrontation = to examiner, PERRLA, EOMI without nystagmus
Eyes, Eyelids, Eyebrows- symmetrical, without edema, masses, lesions, deformities or tenderness.
Conjunctiva- moist, not injected, palpebral conjunctiva pink.

Sclera- no jaundice (icterus), hemorrhage, or injection.
Lacrimal apparatus without inflammation, edema, or regurgitation.
Cornea and Lens- without opacities.
Funduscopic- Disc margins sharp, C/D ratio ; A/V ratio , without nicking; macula disc widths laterally (or not visualized). No hemorrhage or exudate.

RESPIRATORY
Inspection- symmetrical, without edema, masses, lesions, or deformities.
AP ratio-__: _. No inspiratory or expiratory retraction.
No masses or tenderness.
Respiratory excursion- symmetrical.
Tactile fremitus- = bilaterally.
Resonant to percussion.
Diaphragmatic excursion- __cm bilaterally.
Breath sounds- vesicular, without adventitious sounds.
Bronchophony present/absent (or egophony, or whispered pectoriloquy).

CARDIOVASCULAR
Skin- tone and turgor good.
Extremities- Warm, pink, & moist without edema.
Hair- normal adult distribution.
Chest and Neck- Symmetrical, no edema, masses, lesions, or deformities.
No heaves. PMI at __. (or PMI not visualized.)
Jugular Venous Pulses (JVP)- ___cm at __ degrees.
Allen Test- symmetrical, refill < 2 seconds.
Digital capillary refill, by blanching, < 2 seconds.
No pitting edema.
Homan's sign- negative.
PMI- LMCL, 5th ICS, without thrills.
Peripheral pulses- All pulses 4+, scale of measurement- 0 = absent, 4+ = normal. (list pulses separate with different strengths)
S1, S2- rate and rhythm regular (RRR), without gallops, murmurs, rubs, or splitting.
Carotids and Abdomen- without bruits.

BREASTS
Size- Moderate size, L slightly > R, uninterrupted contour.
Color- pale, with pronounced venous pattern bilat; without erythema, hyper or hypopigmentation.
Skin- soft, smooth, no masses, dimpling, retraction or flattening.
Nipples- erect without discharge.
Areola- symmetrical with Montgomery tubercles, without masses, lesions, crusting, scaling, or discharge.
Axillary Lymph nodes- Without lymphadenopathy.

GASTROINTESTINAL

Inspection-Flat (or scaphoid), symmetrical; without masses, lesions, or deformities.
Aortic pulse- present in epigastrium. (or absent)
Bowel sounds- present in all 4 quadrants. No abdominal bruits.
Liver span-__ cm, RMCL.
Spleen- percussed at _____ . (or unpercussable)
Gastric Bubble- percussed at ____ . (documented only if enlarged)
Kidneys- No CVA tenderness.
No ascites, masses, guarding or tenderness, including rebound.
Liver, Spleen, Kidneys- unpalpable, nontender.
Obturator and Psoas- negative.
Aortic pulse- __cm diameter.

GENITOURINARY
(MALE)
Penis and Groin- Without edema, masses, lesions, deformities, hernias or tenderness.
Glans- circumcised (or uncircumcised), no phimosis, edema, masses, lesions, tenderness, or urethral discharge.
Scrotum- nontender without edema, masses, lesions, deformities, hernias.
Testes- firm, ovoid, equal size, without masses or tenderness.
Epididymis- superior and posterior; without masses or tenderness.
Spermatic cord-without masses or tenderness.

GENITOURINARY
(FEMALE)
External Genitalia- Normal adult female with stage 5 escutcheon, without masses, lesions, deformities or Urethral orifice, Skene's and Bartholin's glands- without discharge
Vagina- Mucosa pink, moist, with rugae and without masses, lesions, deformity, discharge, or tenderness.
Cervix- Pink, os nulliparous or multiparous . No masses, lesions, deformity, discharge, or tenderness.

RECTAL-
Perianal region- without masses, lesions or hemorrhoids.
Sphincter tone good- without anal tenderness.
Rectal wall - smooth, no masses or fissures. Stool in vault, brown.
Guaiac- negative.
Prostate (male exam)- consistency, size, shape, no masses or tenderness. Median sulcus midline.

NEUROLOGICAL
MENTAL STATUS EXAM-
CRANIAL NERVES-
CN-I- Identified and discriminated odors of __ and __, bilaterally.

CN-II- V/A- __/__OD, OS, (or OU). Visual fields by confrontation = to examiners. Funduscopic.

CN-III, IV, VI- PERRLA, EOMI, no nystagmus.

CN-V- Temporal and masseter muscles- symmetrically strong, intact to light touch, sharp/dull, hot/cold. Corneal reflex intact.

CN-VII- Facial movements (eyebrows raise, lids close tight, smile, frown, retract lips, whistle, puff) symmetrical, no weakness, tics or tremors. Discriminates sweet/salt.

CN-VIII- Weber = bilat., Rinne AC>BC.

CN-IX, X- Swallowing and Gag reflex intact. Uvula rises midline.

CN-XI- Head movements and shoulder shrug symmetrically strong, against resistance.

CN-XII- Tongue midline, symmetrical, no tremors.

MOTOR- No atrophy, weakness or tremors.

CEREBELLAR- Point to point and rapid alternating movements (RAM)- speed and rhythm consistent, movement fluent.

Negative Romberg.

GAITS- Heel-to-toe, heel and toe walk, and normal ambulation- appropriate arm swing, without loss of balance or hesitation.

SENSORY- Bilaterally intact to; light touch, pin prick, two-point discrimination, hot/cold, proprioception (digit position with eyes closed), and stereognosis (object identification with eyes closed.

DTR's- (0-4+, 2+ = normal) (draw diagram with plus signs). No ankle clonus..

Babinski- absent.

Kernig's, Brudzinski's- Negative.

NOTE: If accomplished during previous exams, annotate "see ____exam".

MUSCULOSKELETAL

(ROM: passive and active)

TMJ-

INSP- No edema, masses, lesions, or deformities.

PALP- No tenderness or crepitus bilat.

ROM- FROM (full range of motion), no locking, dislocation, or crepitus.

NECK-

INSP- No edema, masses, lesions, or deformities.

PALP- No tenderness

ROM- FROM, no tenderness

SHOULDERS-

INSP- No edema, masses, lesions, deformity, or atrophy.

PALP- No point tenderness. Acromioclavicular (AC), sternoclavicular (SC) joints and shoulders, no tenderness.

ROM- FROM, no tenderness.

ELBOWS-
INSP- No edema, masses, lesions, deformities, or tophi.
PALP- Extensor surface of ulnar and olecranon processes, no masses, swelling, or tenderness. Lateral epicondyles, no tenderness.
ROM- FROM, no tenderness or crepitus.

HANDS AND WRISTS-
INSP- No edema, masses, lesions, deformities, or atrophy.
PALP- No edema, bogginess, crepitus, tenderness, or bony enlargement of MCPs, PIPs, or DIPS. No edema, bogginess, or tenderness of wrists.
ROM: FROM hands and wrists, no crepitus or tenderness.
VASCULAR AND NEURO CHECK: (Note: temperature, capillary refill, blanching, strength, sharp/dull discrimination)

SPINE-
INSP- Spinal profile with normal cervical, thoracic and lumbar curves. Level of shoulders, iliac crests, and buttocks, = bilat.
PALP- Spinous processes and paravertebral muscles nontender and no trigger points.
ROM-
Flexion, lateral bending, extension, and rotation- without difficulty or tenderness.
Straight leg raise- to ^{o}, without tenderness or sciatica bilat.
Great toe dorsiflexion- without tenderness bilat.

HIPS-
FROM, no tenderness. External rotation, flexion, abduction, and internal rotation without difficulty or tenderness bilat.

KNEES-
INSP- No edema, masses, lesions, deformity, or asymmetry. Medial hollows present.
PALP-No thickening, bogginess, or tenderness. No bony enlargement around joints. No thickening, bogginess, or fluid around patella or over tibiofemoral joint space. No tenderness of joint spaces or femoral epicondyles. No edema or cysts in popliteal spaces.
Tibial tuberosities- no edema, masses, or tenderness.
Bulge and ballotment- negative bilat.
Collateral ligament,- stable.
Drawer sign and McMurray sign- negative bilat.
ROM- FROM, no tenderness or crepitus.

FEET AND ANKLES-
INSP-
Feet- no edema, masses, lesions, deformity, calluses.
Ankles- no edema, masses, lesions, deformity, or discoloration.
PALP-
Ankles- no edema, masses, bogginess or tenderness.
Achilles tendons- no masses or tenderness.
Metatarsophalangeal joints (MTPS)- nontender.

ROM- Ankle, foot (eversion and inversion), and toes, FROM, no crepitus or tenderness.
VASCULAR AND NEURO CHECK- (temp., pedal pulses, blanching, strength, sharp/dull discrimination)

Please click here for a presentation entitled Recording Medical Histories. Part of the presentation appears below.

RECORDING MEDICAL HISTORIES
Section A
The PCM Technician

- ✪ As we progress in our efforts to develop true "primary care management teams," the medical technician will be called upon to perform a variety of tasks in support of community health management and clinical preventive services. A fundamental goal here is to optimize the professional provider's time while nurturing an integrated health care "team" that gives our customers quality service.

Section B
Reviewing the Basics

-Review the record prior to interview (Should be doing this anyway as part of preventive services)
-Factors in the History Taking Process
--Setting
---Insure pt comfort, seating at eye level with interviewer
---Pt gets your FULL attention, avoid interruptions
---Privacy, safety, and modesty---A MUST!
--Be a good communicator, work on skills that show interest, attention, acceptance, and understanding
---Eye contact
---Posture
---Gestures
---Words
--DO NOT express negative reactions to pt information
--Questioning
---Help guide the patient using:
----Facilitation ("Mm-hmm, Go on")
----Reflection (Repeating encourages detail)
----Clarification ("Tell me what you meant by…")
---Direct questions, go from general to specific
---Develop the Attributes of Symptoms
----O,P,Q,R,S,T
---AVOID leading questions

Clinical Reasoning

- ✪ As you progress in proficiency, you will begin to recognize certain "sets" of symptoms can be related to specific abnormalities and disease processes. This, in turn, will lead you to start thinking about bodily systems that are involved and help you direct your interview to more specific questions.
- ✪ OPTIONAL READING ASSIGNMENT----------Read Chapter 2, Barbara Bates,

Guide to Physical Examination

- In conjunction with the history, a physical examination of the involved systems confirms or denies physical findings associated with suspected diseases or injuries. This cumulative evaluation (history+physical) then results in the providers assessment (SOAPP).
- Be aware that, at times, the assessment may be several possible, but not yet confirmed diagnoses. In these cases, the Plan of Care (SOAPP) will include further tests or procedures to help "rule out" some of the probable diagnoses.
- A good working knowledge of specific diseases and their associated symptoms will come through your own self-study and through clinical experience in working very closely with your PCM provider.
- Although most won't admit it, providers love being teachers!

Skilled Technician Support

- In keeping with our goal of optimizing provider time, we eventually expect that you will be able to anticipate your providers physical exam approach based on the history. You may also be able to predict ancillary tests the provider will order to "rule out" certain conditions.
- This is one area where your skilled support can definitely save time.
- Knowing the involved systems (and your provider approach), you will be responsible to insure the patient is appropriately prepared for the physical exam and that all materials needed for the exam (instruments, supplies) are pre-positioned so as to expedite the process.
- Remember that at all times but especially at this point in the process, you must continuously keep the patient informed of any delays in seeing the provider. THIS IS AN EXTREMELY IMPORTANT COURTESY THAT MUST NOT BE OVERLOOKED!
- You will also assist the provider with the exam and any special procedures and will come to realize this can be a great learning experience.
- Again, clinicians will differ in their approach and some adaptation is expected, but you are now on your way to becoming a truly cohesive "Provider/Technician Team" that provides thorough, skillful care in a minimum amount of time.
- Early on, we expect you will feel uneasy and uncertain performing in this "new role".
- Over time, however, as your competence and self-confidence grow, the flow of interviews and examinations will become very smooth and you will begin to build a trusting working relationship with your provider.
- The vision here is a primary care environment where the right person does the right process at the right time (And The Patient Gets Quality Care Every Time!)

Verbal Communication
With Providers

As a PCM technician, you will need to become very proficient at not only writing, but also speaking in terminology that communicates to your provider the patient's history.

It is not necessary to read to the provider what you have written, you do however, need to quickly give a synopsis of the pertinent positives and negatives from the interview.

This informal report must be organized in a format acceptable to your provider and must

effectively relay the patient's presentation.

Again, no two providers will want the same presentation and you will probably find that some variation is a beneficial learning experience.

You are not expected to be an expert immediately, as this skill takes time and experience to fully develop. With self-study and practice however, you will soon build a working relationship that runs like "clockwork".

Practice Exercise
Section C
Problem Oriented (Short)
SOAPP Notes

- The SOAPP note is the standard format used to record patient progress notes in an outpatient setting. The acronym refers to:
  - S = SUBJECTIVE
  - O = OBJECTIVE
  - A = ASSESSMENT
  - P = PLAN
  - P = PREVENTION

S = SUBJECTIVE

- This is basically what the patient tells you and is your primary area of concern when recording information for the provider. Subjective information includes (suggested structure):
  - Patient Identification
  - Chief Complaint (c/c)
  - History of Present Illness (HPI) "OPQRST"
    - Associated Symptoms
  - Current Meds
  - Allergies
  - Pertinent Social History
- Patient Identification: Age, sex, race, occupation, status
  - Example: 18 y/o WM ADAF Med tech
- Chief Complaint: If possible, in patient's own words
  - Examples: presents with "I have a painful click in my knee" OR
  - presents with c/o L Knee pain x 3 days
- History of Present Illness (HPI) - This is where we begin to develop the Symptom Attributes to fill in the details. A common method is using "OPQRST", which we'll explain in the following slides.
- HISTORY OF PRESENT ILLNESS
- O: Onset (When/How did it start?)
- P: Provocative/Pallitative (What makes it better/worse?)
- Q: Quality (Sharp, dull, aching, throbbing?)
- R: Region/Radiation (Where is it, does it radiate?)
- S: Severity/Strength (Scale of 1-10? compared to? Any limitations?)

- ✪ T: Time/Treatment (Had before? When? Compare then and now? Duration? Treatment - if meds include exact dose/frequency, relief from treatment?)
- ✪ HISTORY OF PRESENT ILLNESS
- ✪ While we realize that "OPQRST" may not exactly apply to every patient presentation, it is certainly a good starting point when beginning interviews.
- ✪ HPI may also include pertinent questions about past medical history, immunizations, habits, hobbies, religious preference, living conditions, finances, exposures, family history, or other associated symptoms based on the suspected systems that are involved. This will become more familiar to you with extended experience.
- ✪ HISTORY OF PRESENT ILLNESS
- ✪ Other appropriate questions for female patients with potential OB/GYN disorders:
  - Gravida/Para?
  - Last Normal Menstrual Period (LNMP)?
  - Sexual Activity?
  - Method of Birth Control (incl. problems I.e. missed pills)
- ✪ Current Medications (May already be noted in HPI)
  - Include dosage/frequency/relief or effectiveness
  - Ask about preparations commonly not considered meds
    - Aspirin
    - Vitamins
    - Birth Control Pills
- ✪ Allergies - Drugs? Insects? Food? Other?
- ✪ Pertinent Social History - Remember the Stages of Change and appropriate intervention counseling techniques.
  - Tobacco - (smoke, dip or chew) frequency/quantity?
  - Alcohol - Type/frequency/quantity?
  - Life style - Diet, exercise?
- ✪ NOTE: AFI 40-102 requires that EVERY patient be queried about their history of tobacco use during EVERY encounter with medical and dental personnel

SOAPP NOTES
O = OBJECTIVE

- ✪ This is what is observed in the patient by medical personnel and includes:
  - Vital Signs
  - General Impression
  - Physical Exam
  - Results of any same day procedures/lab tests
- ✪ The majority of Objective information comes from the provider however, you provide vital sign information and may be called upon to provide the general impression. Example: 28 y/o well developed, well nourished, black male, oriented and in no acute distress

SOAPP NOTES
A = ASSESSMENT

- ✪ Based on the Subjective and Objective information, this is the providers evaluation of what is going on with the patient. It may be a single diagnosis or a list of several probable diagnoses.
- ✪ As we mentioned earlier, if there is a list of probable diagnoses, then the Plan (P) will include further procedures or tests to help confirm or "rule out" some of the suspected causes of the patient's problem.

SOAPP NOTES
P = PLAN

- ✪ This is the providers plan of care for the patient and generally includes:
  - The actual treatment mechanism
    - Meds (strength, dose, frequency, ROA, #given, refills)
    - Therapy
    - Crutches
    - Other
  - Further Testing (Lab, X-ray, ECG, etc.)
  - Admin Support (Sick Slip, Profile, PRP recommendation)
  - Patient Instructions (DOs/DON'Ts)
  - Expectation of wellness
  - Follow-up instructions

SOAPP NOTES
P = PREVENTION COUNSELING

- ✪ This is done during every patient visit and is where we formally document advice given to the patient about high-risk behaviors identified during this visit and also for official referrals for further education from community based services. Example: HAWC
- ✪ It is done in addition to addressing preventive health topics on DD Form 2766 as part of a PHA or HEAR evaluation (Reference: AFPAM 44-155, 16 Nov 98)
- ✪ To assist you in performing this task (counseling), you will be given further training in counseling techniques for lifestyle risk factor reduction.

SOAPP NOTES
Sample Technician Entry

- ✪ S - 18 y/o WM, ADAF Amn, personnel tech, c/o "my L knee hurts" x 3 days. Playing basketball, jumped to shoot, upon landing twisted knee with immediate pain/swelling. Used ice/rest but continued pain, worse with activity (standing, marching, running), better with rest. Pain located laterally, throbbing, without radiation. No popping/locking but unstable with lateral movement. No Hx of knee injury, No significant PMH, NKDA.

Meds - Advil 200mg, 2 tabs BID x 2 days with some relief. SH - denies tobacco or ETOH use

- O - VS: BP 110/80 R12 P80 T97.6, Gen Imp: Well male in NAD, ambulates with limp

Legal Considerations

- To complete this read ahead module it is important that we discuss risk management considerations. Your behavior during the entire episode of care must remain above reproach. Specifically:
- During the interview:
  - DO NOT express negative reaction to any pt information
  - Avoid appearing flippant, non-caring or combative
  - Avoid sexual banter, dirty jokes or crude language (unless this is the only thing the patient will understand)
  - Ensure privacy and safety at all times
- During the Physical Exam (with your provider):
  - Keep the patient advised of any delays
  - Ensure safety and privacy at all times
  - Always chaperone when appropriate
  - Explain what is being done and why, ensure the patient understands
  - Give honest answers (to include "I don't know, but we'll find out") when the patient ask for information
  - Know your job! Always demonstrate that you are a professional, and a key member of the healthcare team.
- In the Medical Record:
  - You must be aware that anything written in the healthcare record has the potential to become legal evidence in a court of law. Some Documentation Tips:
    - Anytime you write in a medical record insure the complete pt ID information is on the form you are writing on (not writing in John Jr.'s record when your caring for John Sr.)
    - Write neatly and legibly in blue/black ink - A MUST!
    - DO NOT write editorial comments or opinions, be like Joe Friday (Dragnet) "Just the Facts"
    - DO NOT alter a medical record (even coffee stains). Errors are struck through with a single line, initialed and dated
    - Your provider should always document any follow-up instructions given to the patient

3. Charting Specific Health Problems

The reengineered Military Health System will use standardized charts to record specific patient information. All personnel charting the following, specific complaints and conditions will need to use the same forms.

This section includes forms for charting common complaints and encounters: standard office visits, blood pressure, ankle injuries, cholesterol, coumadin, ear pain, low back pain, sore throat, URI, UTI, vaginal discharge, and vomiting and diarrhea. To view a particular form, click on it below.

- Standa~1 (Standard Chart)
- 2dayBP (2-day Blood Pressure)
- ankles~1 (Ankle injuries)
- chol1 (Cholesterol)
- coumad-pharm priv (Coumadin)
- earpain (Ear pain)
- lbp (Low back pain)
- sorethro (Sore throat)
- URI
- UTI
- Vaginal discharge
- Vomiting/diarrhea

TRAINING SUPPORT PACKAGE: MEDICAL RECORDS MANAGEMENT

The Army developed a training program to teach methods for accounting for, transferring, receiving, filing, and storing medical records. The program covers the entire process, from the first assembly of the medical record to its retirement. Although the Army developed the training materials, the content is equally applicable and usable throughout the Military Health System.

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG024
TSP Title	Medical Records Management
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for: MEDICAL RECORDS MANAGEMENT

This TSP
Contains

TABLE OF CONTENTS

HPABG024 version 1 / Medical Records Management
28 May 1998

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
513-71G10	Patient Admin Specialist
513-71G10 (RC)	Patient Admin Specialist (RC)

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0208	Maintain Medical Records for Personnel Enrolled in the Personnel Reliability Program
081-866-0209	Forward Medical Documents/Records to the Proper Custodian
081-866-0210	Dispose of Unidentifiable Records and Forms
081-866-0211	Dispose of a Health Record (HREC)
081-866-0212	Retire an Outpatient Treatment Record (OTR)

Academic Hours

The Academic hours required to teach this TSP are as follows:

	ADT Hours/Methods
	5.0 / Conference / Discussion
Test	0.0 /
Test Review	0.0 /
Total Hours:	5.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
None	

Clearance Access

Security Level : Unclassified
Requirements : There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
HSC PAM 40-7-5	Ambulatory Patient Care Outpatient Medical Records Improvement Actions	03 Apr 1985	
AR 40-66	Medical Record Administration (20 Jul 92)	01 Jan 1900	
AR 50-5	Nuclear and Chemical Weapons and Material-Nuclear Surety (Reprinted w/Basic Incl C1, 07 Aug 89) (03 Oct 86)	01 Jan 1900	
DA Form 8005	Outpatient Medical Record (OMR) Orange	01 Jan 1900	
DA Form 3444-Series	Terminal Digit File for Treatment Record	01 Jan 1900	
AR 25-400-2	The Modern Army Recordkeeping System (MARKS) (26 Feb 93)	01 Jan 1900	

Student Study Assignments

None

Instructor Requirements

One (1) MOS 71G Qualified Instructor

Additional Personnel Requirements

None

Equipment Required for Instruction

Name	Quantity	Expendable
Screen, Projector	0	No
Projector, Still, 35mm	0	No

Materials Required

Instructor Materials:
35mm slide projector, hand control, and screen
Slides S HPABG024 01-

Student Materials:
Student handout "Medical Records Management Student Handout M HPABG024 01"

Classroom, Training Area, and Range Requirements

CLASSROOM 48 PER,TABLES

Ammunition Requirements

Name	Student Qty	Misc Qty
None		

Instructional Guidance

NOTE: Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material.

The Instructor should distribute student hand-outs prior to the start of classroom presentation.

Proponent Lesson Plan Approvals

Name	Rank	Position	Date

SECTION II. **INTRODUCTION**

Method of Instruction: Conference / Discussion

Instructor to Student Ratio is: 1:45
Time of Instruction: 5 hrs
Media: PRINT

Motivator

Maintaining records with efficiency and positve control results in a pleasant work environment and contented patients.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage medical records and documents.
Conditions:	Given AR 40-66, Medical Record Administration, AR 50-5, Nuclear & Chemical Weapons and Materials-Nuclear Surety, Medical Documents, DA Form 3444-series or DA Form 8005-series folders, and APV records, HSC Pam 40-7-5, Ambulatory Patient Care and Outpatient Medical Records Improvement Actions, AR 25-400-2, The Modern Army Recordkeeping System (MARKS).
Standards:	The soldier must manage medical records and documents IAW AR 40-66 and AR 50-5.

Safety Requirements

Local S.O.P.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Knowing the skills of assembling and organizing medical records is very important. Properly organized records are essential to health maintenance of the soldiers whose well-being is our responsibility. But, proper assembly and maintenance of the records is only a part of the job. Things such as accounting for records, transferring and receiving records, and filing and storage of records are just as important. From when medical records are first assembled to when that are retired, there must be dedicated procedures for ensuring their longevity. In this lesson, that is what we will discuss: "Medical Records Management."

Slide S HPABG024 01.

SECTION III. **PRESENTATION**

A. ENABLING LEARNING OBJECTIVE A

ACTION:	Screen an incoming medical record.
CONDITIONS:	Given AR 40-66.
STANDARDS:	The soldier must screen an incoming medical record IAW AR 40-66.

1. Learning Step / Activity 1. Receiving the record.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 02: Receiving the Record

a. Record receipt of the incoming medical record.
b. Initiate a new jacket if the medical record jacket is mutilated.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Checking the medical record for correct entries.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 03: Checking for Correct Entries

a. Check DA Form 3444 or DA Form 8005 series for correct information and completeness.
(1) Patient identification
a) Name.
b) Family member prefix (FMP).
c) Sponsor's social security number.
d) Unit (only on health records).
e) Blood type (only on health records).

Slide S HPABG024 04: Checking for Correct Entries

(2) Check note to physician.
a) Medical condition.
b) Personnel Reliability Program (PRP) screening.

c) Radiation screening program.
d) Flight status.
e) Medical registries.

Slide S HPABG024 05: Checking for Correct Entries

(3) Check type of record.
a) Inpatient (clinical).
b) Outpatient treatment.
c) Health.

NOTE: "Health" should be the only box checked under type of record on a Health Record.

Slide S HPABG024 06: Checking for Correct Entries

d) Health-Dental.
e) Dental (nonmilitary).
(4) Check for a signed Privacy Act Statement (DA Form 2005).

Slide S HPABG024 07: Checking for Correct Entries

b. Check the record contents for proper sequence of forms and completeness of patient identification information.

NOTE: Copies of the same form shall be grouped together and filed in reverse chronological order.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Review SF 88, Report of Medical Information.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 08: Report of Medical Examination, SF 88F

a. Check the patient information in blocks 1 through 17.
b. Check items 18 through 43 for completeness.

NOTE: Item 43 pertains to females only.

Slide S HPABG024 09: Report of Medical Examination, SF 88B

c. Check items 17 through 47for required entries.
d. Check for signatures.
e. Return to the physician for completion, if necessary.
f. File the completed form in the patient's record.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Review SF 93, Report of Medical History.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 10: Report of Medical History, SF 93F

a. Ensure the patient's identification and administrative data have been recorded.
b. Ensure the patient has completed the medical history and health data sections.
c. Ensure the patient has signed the form.

Slide S HPABG024 11: Report of Medical History, SF 93F

d. Ensure the physician has completed item 25, if applicable.
e. Ensure the physician's name and date have been entered.
f. Return the form to the physician for completion, if necessary.
g. File the completed form in the patient's record.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Forward the medical record.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 12: Forward the Medical Record

a. Review of health records (HRECs) may be conducted by a medical officer, a physician's assistant, or other qualified individuals.
b. Forward the health record to the appropriate Army Medical Department (AMEDD) personnel for review.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	Maintain medical records for personnel enrolled in the Personnel Reliability Program (PRP).
CONDITIONS:	Given AR 40-66, and AR 50-5.
STANDARDS:	The soldier must Maintain medical records for personnel enrolled in the Personnel Reliability Program (PRP) IAW AR 40-66, AR 50-5, and AR 50-6.

1. Learning Step / Activity 1. Overviewing the Personnel Reliability Program (PRP).

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 13: Personnel Reliability Program (PRP)

a. Purpose of the PRP.
(1) Provides guidelines for the Army to identify nuclear duty positions.
(2) Provides a means of assessing the reliability of individuals whom are being considered for assignment to nuclear duty positions.

Slide S HPABG024 14: Personnel Reliability Program (PRP)

b. Personnel eligible for assignment to the PRP.
(1) Acive duty personnel.
(2) DOD civilian employees.
(3) Civilian contract personnel.

Slide S HPABG024 15: Personnel Reliability Program (PRP)

c. Disqualifying conditions.
(a) Alcohol abuse.
(b) Drug abuse.
(c) Any physical condition which may impair judgement.
(d) Lack of motivation.

(e) Negligence of duty.
(f) Punitive processes (Article 15 or Court Martial).

Slide S HPABG024 16: Personnel Reliability Program (PRP)

d. Medical record functions.
(1) Used for medical evaluation to determine medical and mental fitness.
(2) Screened periodically for all perconnel assigned to the PRP.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Segregate Health Records (HRECs) for personnel enrolled in the PRP.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 17: Personnel Reliability Program (PRP)

a. Ensure records are maintained under continuing evaluation.
b. Establish a cross reference system to account for the absence of these records from the central files.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Ensure the chain of custody in the handling of PRP records is not broken.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 18: Personnel Reliability Program (PRP)

a. Sign out the records during the duty day.
b. Ensure the PRP record is returned before the close of business the same duty day.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Label PRP records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 19: Personnel Reliability Program (PRP)

a. Mark the PRP block on the record folder to indicate participation in the program.
b. File DA Form 3180-R (Personnel Screening and Evaluation Record) as the top document on the left side of the folder in DA Form 3444 series jackes and directly under the DA Form 4515 in the 8005.
c. File DA Form 4515 (Personnel Reliability Program Record Identifier) as the top document on the right side of the folder in DA Form 3444 series jackets and top document of part II of DA Form 8005 series jacket.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Screen PRP records upon transfer.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 20: Personnel Reliability Program (PRP)

a. Ensure the gaining and loosing MTFs screen the PRP record per AR 50-5 or AR 50-6.
b. Annotate the SF 600 with "Preceding entries screened under provisions of AR 50-5 (or AR 50-6)" followed by the screener's printed name, grade and signature.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	Forward medical records and loose documents to the proper custodian of the medical records.
CONDITIONS:	Given AR 40-66, medical records, and loose documents.
STANDARDS:	The soldier must forward medical records and loose documents to the proper custodian IAW AR 40-66.

1. Learning Step / Activity 1. Screen the records or documents against the MTF files.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 21: Screen Records or Documents

a. When a soldier out-processes, the Medical Treatment Facility (MTF) will record the new record custodian and cross reference charge-out folders, log books, etc., so that any late arriving records/documents can be forwarded to the current custodian
b. Identified files (files matched with a record or suspense card) will be sent to the proper custodian. The letter of transmittal will name the member's assigned unit.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Determine the proper custodian.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 22: Screen Records or Documents

a. If possible, access the Defense Enrollment Eligibility Reporting System (DEERS) to determine the current custodian.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Forward list of members to servicing MILPO (military personnel office)/post locator.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 23: Forward List to MILPO/Post Locator

a. Include full name, SSN, and unit of assignment (if possible).
b. Attach a cover letter requesting the names be checked.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Forward the records/forms to the current custodian provided by the MILPO.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 24: Forward Records/Forms to Custodian

a. If the MILPO or post locator cannot find the address of the proper custodian forward the documents to the custodian as shown in the rules outlined in AR 40-66, paragraphs 5-26 d (3) (a) through (f).

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

D. ENABLING LEARNING OBJECTIVE D

ACTION:	Dispose of unidentifiable medical records and forms.
CONDITIONS:	Given AR 40-66.
STANDARDS:	The soldier must dispose of unidentifiable records and forms IAW AR 40-66.

1. Learning Step / Activity 1. Dispose of unidentifiable medical records and forms.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 25: Dispose of Unidentifiable Records

a. Prepare a report listing the types of documents or records (for example, laboratory form; x-ray reports;
(SF 600, and so on) and the number of each type to be destroyed.
b. Obtain the patient administrator's signature on the report.
c. Forward the report to the MTF committee that audits medical records.
d. Upon the committee's approval, destroy the unidentifiable records and forms.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

E. ENABLING LEARNING OBJECTIVE E

ACTION:	Transfer a Health Record (HREC)/Outpatient Treatment Record (OTR).
CONDITIONS:	Given AR 40-66.
STANDARDS:	The soldier must transfer a HREC/OTR IAW AR 40-66.

1. Learning Step / Activity 1. Disposition of Army health records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 26: Disposition of Health Records

a. Change of station (PCS): records (health and dental) are hand carried by the soldier.

NOTE: The losing custodian may send the soldier's records directly to the commander of the gaining MTF if he feels the records should not be hand carried.

Slide S HPABG024 27: Disposition of Health Records

b. Separation from the service: the records are forwarded to the military personnel officer overseeing the separation.

c. AWOL (over 10 days): the records are forwarded to the officer holding the soldier's military personnel records.
d. Death: the records are forwarded to the office holding the patient's personnel records.

Slide S HPABG024 28: Disposition of Health Records

e. Retirement of the service member:
(1) Normal retirement: the records are forwarded to the military personnel officer overseeing the retirement.
(2) Possible VA compensation: the records are forwarded to the VA regional office nearest patient's place of retirement.
(3) VA hospitalization: the records are forwarded to the VA hospital where the patient is hospitalized.

Slide S HPABG024 29: Disposition of Health Records

f. Maintenance of health records during combat conditions:
(1) The personnel officer will file the records with the service member's military personnel records.
(2) Forms received from a MTF (aid stations, clearing stations, etc.) will be filed in the records.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Tranferring the records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 30: Transfer of Health Records

a. Both parts (health and dental) will be transferred (may be hand carried) when the service member's military personnel record is transferred.
b. The Personnel Officer of the gaining unit will receive the records from their custodian.

Slide S HPABG024 31: Transfer of Health Records

c. Exception:
(1) When the losing and gaining units receive their primary care from the same MTFs and DTFs.

(2) When an inpatient is assigned to a medical holding unit that already has the records.
(3) When the losing unit sends the records directly to the gaining unit.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

F. ENABLING LEARNING OBJECTIVE F

ACTION:	Dispose of an HREC.
CONDITIONS:	Given AR 40-66.
STANDARDS:	The soldier must dispose of a HREC IAW AR 40-66.

1. Learning Step / Activity 1. Determine the type of separation.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 32: Type of Separation

a. Separating from the service.
b. Death .
c. Normal retirement.
d. Retirement with possible Veterans Affairs (VA) compensation.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Forwarding the HREC to the appropriate office.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 33: Forwarding the HREC

a. For a soldier separating from the service, forward the record to the military personnel officer handling the separation.
b. For death of the soldier, forward the record to the office holding the patient's personnel records.

Slide S HPABG024 34: Forwarding the HREC

c. For normal retirement, forward the record to the officer handling the separation.
d. For retirement with possible Veterans Affairs (VA) compensation, forward the record to the VA regional office nearest the patient's place of retirement.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

G. ENABLING LEARNING OBJECTIVE G

ACTION:	Retire an Outpatient Treatment Record (OTR).
CONDITIONS:	Given AR 40-66, AR 25-400-2, DA Form 3444-Series Folder, and DA Form 8005-Series Folder.
STANDARDS:	The soldier must retire an OTR IAW AR 40-66 and AR 25-400-2.

1. Learning Step / Activity 1. Prepare the records for retirement.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: Peer instruction

Slide S HPABG024 35: Prepare Records for Retirement

Note: Records shall be maintained for 3 years after the end of the year in which last medical treatment was given.

Slide S HPABG024 36: Prepare Records for Retirement

a. Determine the appropriate year that the OTR will be retired 3 years after the end of the year that the last medical treatment was given.
b. Retrieve the outpatient records for retirement from the OTR files.
c. Segregate the records based on the Modern Army Recordkeeping System (MARKS) file number (retired military, civilian, etc.).

Slide S HPABG024 37: Prepare Records for Retirement

d. File the records for retirement, using the terminal digit filing system, in record shipping cartons.

(1) Record the first and last record, MARKS file number, and carton series (1 of 12; 2 of 12, etc.) on each carton.
(2) Prepare a letter of transmittal for each shipment, segregated by MARKS file numbers.

Slide S HPABG024 38: Prepare Records for Retirement

e. Forward all letter(s) of transmittal to the National Personnel Records Center for their acceptance and issuance of
accession numbers.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Transfer the records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 39: Transfer the Records

a. Receive the accession numbers.
b. Forward the retired records to: National Personnel Records Center, 9700 Page Blvd, St. Louis, MO 63132.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

H. ENABLING LEARNING OBJECTIVE H

ACTION:	Retire an Inpatient Treatment Record (ITR)/Ambulatory Procedure Visit (APV)/Observation Record.
CONDITIONS:	Given AR 40-66 , AR 25-400-2, and DA Form 3444-Series Folder.
STANDARDS:	The soldier must retire an ITR/APV/Observation Record IAW AR 40-66 and AR 25-400-2.

1. Learning Step / Activity 1. Prepare the records for retirement.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 40: Prepare the Records

a. Determine the appropriate year that the ITR will be retired.
(1) Maintain the records for teaching facilities for 5 years after the end of the year that the last medical treatment was given.
(2) Maintain the records for the U.S. Military Academy for 3 years after the end of the year that the last medical treatment was given.

Slide S HPABG024 40A: Prepare the Records

(3) Non-teaching hospital 1 year after the end of the year that the last medical treatment was given.

Slide S HPABG024 41: Prepare the Records

b. Retrieve the outpatient records for retirement from the OTR files.
c. Segregate the records based on the Modern Army Recordkeeping System (MARKS) file number (retired military, civilian, etc.).

Slide S HPABG024 42: Prepare the Records

d. File the records for retirement, using the terminal digit filing system, in record shipping cartons.
(1) Record the first and last record, MARKS file number, and carton series (1 of 12; 2 of 12, etc.) on each carton.
(2) Prepare a letter of transmittal for each shipment, segregated by MARKS file numbers.

Slide S HPABG024 43: Prepare the Records

e. Forward all letter(s) of transmittal to the National Personnel Records Center for their acceptance and issuance of
accession numbers.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Transfer the records.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45

Media: PRINT

Slide S HPABG024 44: Transfer the Records

a. Receive the accession numbers.
b. Forward the retired records to: National Personnel Records Center, 9700 Page Blvd, St. Louis, MO 63132.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

I. ENABLING LEARNING OBJECTIVE I

ACTION:	Operate a Record Control Program.
CONDITIONS:	Given AR 40-66 and HSC Pam 40-7-5.
STANDARDS:	The soldier must operate a Record Control Program IAW AR 40-66 and HSC Pam 40-7-5.

1. Learning Step / Activity 1. Initiation of Record Control.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 45: Operate a Record Control Program

a. Record Control begins when records are released from the files for use in clinic visits, physical examinations, scheduled therapy or consultation, administrative reviews, etc..
b. Records must be accounted for.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Accounting for record removal.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 46: Operate a Record Control Program

a. Upon removal of record a chargeout device should replace the record on the shelf.
b. Chargeout devices consist of "chargeout guides", in a series of five colors, and a chargeout card.

Slide S HPABG024 47: Operate a Record Control Program

c. Chargeout card contains:
    (1) patient identification data.
    (2) date and reason the record is charged out.
    (3) individual's name or clinic to whom the record is released.
d. Card is inserted into the clear plastic pocket of the chargeout guide.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Seven (7) day chargeout policy procedures.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 48: Operate a Record Control Program

a. Medical command policy for return of charged out records is 7 days.

NOTE: MTFs are encouraged to establish a shorter record return policy locally when feasible for additional control.

b. Seven day charge out monitoring uses a 5 color outguide system.
    (1) The same color outguide is used for every record charged out for, any reason, during a 7-day period of time, beginning on a Saturday and ending on the following Friday.

Slide S HPABG024 49: Operate a Record Control Program

    (2) The following Saturday another color of outguide is used, and so on, until four colors of the outguides have been used (white excluded).
    (3) The system provides up to 4 weeks for follow up on records that have not returned to the records room.

Slide S HPABG024 50: Operate a Record Control Program

(4) After 4 weeks, colored outguides from the first week that still remain in the files will be replaced by "white" outguides, annotated with the date.
(5) Saturday of the 5th week, the sequence of use of the colored outguides will be repeated.

Slide S HPABG024 51: Operate a Record Control Program

c. Each Monday, outguides from the previous week, still in the files, must be reviewed and appropriate follow up action initiated.
d. During the first Monday review, if it is determined that a record will not be returned during the next 3 weeks, the colored outguide shall be replaced by a white one, and the charge out card should be annotated with the date and the reason a longer charge out period has been recognized.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Chargeout cards in the outguide system.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 52: Operate a Record Control Program

a. Chargeout cards must be used in conjunction with the outguide system.
b. Chargeout cards must be accurately and legibly recorded with initial information.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Change of custodianship.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 53: Operate a Record Control Program

a. Occurs after the record has been charged out.

b. Requires the record room be notified of the new custodian.

Slide S HPABG024 54: Operate a Record Control Program

c. Procedure for documentation:

(1) Provide a duplicate charge out card with the record when it is originally charged out.

(2) When a custodian releases the record to another custodian, the card may be annotated and return to the records room, tracking the record.

(3) Records room inserts the card in the pocket of the chargeout guide.

Slide S HPABG024 55: Operate a Record Control Program

d. Two advantages of this method:

(1) It eliminates the need for the clinics to maintain a supply of change-of-custody cards.

(2) It eliminates the time required to fill in a blank change-of-custody card.

NOTE: Conduct a check on learning and summarize the learning activity.

6. Learning Step / Activity 6. Messenger service.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:45
Media: PRINT

Slide S HPABG024 56: Operate a Record Control Program

a. A messenger service should be establish to ensure timely serve to patients, physician, and other care providers and to maintain positive control of individual records.

Slide S HPABG024 57: Operate a Record Control Program

b. Duties of messengers should include:

(1) Medical record delivery and pickup service to clinics.

(2) Search for and retrieval of overdue records.

(3) Maintenance of an overdue record log.

(4) Liaison and/or coordination between the outpatient records room and the clinics.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. **SUMMARY**

Method of Instruction: Conference / Discussion

Instructor to Student Ratio is: 1:45
Time of Instruction: 0 hrs
Media: PRINT

Review / Summarize Lesson

During this lesson, you should have become most aware that many things are to be considered in the management of medical records. Everything from their assemblage to destruction has to be done in an orderly and well defined manner. We looked at how to maintain records, how to file, store, and retrieve them, how to dispose of them, how to retire them, how to transfer them, and not to be overlooked, how to operate a Record Control Program to track where they are at all times. If parents gave as much attention to their children, we would all be better off. As a result, it should be evident to you that your management of patient records is one of the most important aspects of you job. Your patient's health depends on it.

Check on Learning

Conduct a check on learning and summarize the lesson.

QUESTION: In the Record Control Program, when is the "white" outguide first used?
ANSWER: Usually at the beginning of the fifth week, but also when it becomes evident that a record will be out for over 3 weeks.

QUESTION: Who may conduct a review of medical records?
ANSWER: a medical officer, a physician's assistant, or other qualified individuals.

QUESTION: What is the purpose of the PRP?
ANSWER: (1) Provides guidelines for the Army to identify nuclear duty positions.
(2) Provides a means of assessing the reliability of individuals whom are being considered for assignment to nuclear duty positions.

QUESTION: What are some of the reasons for disqualification for the PRP?
ANSWER: (a) Alcohol abuse.
(b) Drug abuse.
(c) Any physical condition which may impair judgement.
(d) Lack of motivation.
(e) Negligence of duty.
(f) Punitive processes (Article 15 or Court Martial).

QUESTION: Who gets the health record for a soldier separating from the service
ANSWER: Military personnel officer handling the separation.

QUESTION: Who gets the health record for a soldier who is retiring?
ANSWER: Military personnel officer handling the separation.

QUESTION: Where are retired health records sent?

ANSWER: National Personnel Records Center

SECTION V. STUDENT EVALUATION

NOTE: Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.

Testing Requirements

A written test (50 multi-choice and/or true/false questions) shall be administered testing knowledge of the lessons "Medical Records Management" and "Medical Records II". The student must score a minimum of 70 points to obtain a passing grade.

NOTE: Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

Feedback Requirement

PART F: DIAGNOSTIC/PROCEDURAL CODING

The Army developed a training program to educate personnel to convert medical terminology (diagnosis and/or medical procedure) into numerical format. These numerical codes are used for many reasons, including research, manpower, budget requirements, and billing. The materials address inpatient record coding and outpatient record coding, because the two methods use different methods and resources.

Although the Army developed the training materials, the content is equally applicable and usable throughout the Military Health System.

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG002
TSP Title	Diagnostic/Procedural Coding
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for:

This TSP
Contains

TABLE OF CONTENTS

HPABG002 version 1 / Diagnostic/Procedural Coding
28 May 1998

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
513-71G10	Patient Admin Specialist
513-71G10 (RC)	Patient Admin Specialist (RC)

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0146	Code a Procedure Using CPT4
081-866-0180	Code a Diagnosis or Administrative Data Using the CHCS

Academic Hours

The Academic hours required to teach this TSP are as follows:

	Distance Learning Hours/Methods
	14.0 / Conference / Discussion
Test	0.0 /
Test Review	0.0 /
Total Hours:	14.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
HPABG034	Anatomy & Physiology
HPABG035	Medical Terminology

Clearance Access

Security Level : Unclassified
Requirements : There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification	01 Sep 1980	
CPT 4	Physicians' Current Procedural Terminology	01 Feb 1997	

Student Study Assignments

None

Instructor Requirements	One (1) MOS 71G Qualified Instructor.
Additional Personnel Requirements	None
Equipment Required for Instruction	**Name** **Quantity** **Expendable** None
Materials Required	Instructor Materials: ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification CPT4, Physicians' Current Procedural Terminology, 4th Revision PE1-HPABG002, Assign a CPT4 Code PE2-HPABG002, Assign an ICD-9-CM Code PE3-HPABG002, Complete a DA Form 3647 Student Materials: M-HPABG002, Student Handout ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification CPT4, Physicians' Current Procedural Terminology, 4th Revision PE1-HPABG002, Assign a CPT4 Code PE2-HPABG002, Assign an ICD-9-CM Code PE3-HPABG002, Complete a DA Form 3647
Classroom, Training Area, and Range Requirements	
Ammunition Requirements	**Name** **Student Qty** **Misc Qty** None
Instructional Guidance	**NOTE:** Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material.
Proponent Lesson Plan Approvals	**Name** **Rank** **Position** **Date**

SECTION II. **INTRODUCTION**

Method of Instruction: Conference / Discussion

Instructor to Student Ratio is: 1:44
Time of Instruction: 14 hrs
Media: PRINT

Motivator

SHOW SLIDE S-HPABG002-01

Record coding allows you to convert medical terminology, in the form of a patient's diagnosis or procedure, into a numerical format. These codes are used for a variety of reasons including, research, manpower, budget requirements, and billing.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Select the correct alphabetical/numerical diagnostic and/or procedural code.
Conditions:	Given DA Form 2985, Admission and Coding Information, medical terms, and surgical procedures; DA Form 3647, Inpatient Treatment Record Coversheet; ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification; and Inpatient Data System (IPDS) User's Manual ; a completed Ambulatory Encounter Summary with ambulatory procedures; CPT4, Current Procedural Terminology 4th Revision; AR 40-66, Medical Record Administration; AR 40-400, Patient Administration.
Standards:	Select the correct alphabetical/numerical diagnostic and/or procedural codes IAW the ICD-9-CM, CPT4, DA Form 3647, AR 40-66, AR 40-400, and IPDS User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional

It is important to note that two types of coding are done in medical

Lead-In	treatment facilities, both types will be explained in this lesson. The two types are, Inpatient Record coding and Outpatient Record coding. In each case the reasons for coding the record are basically the same, however, the methods and resources used differ.

SECTION III. PRESENTATION

A. ENABLING LEARNING OBJECTIVE A

ACTION:	Assign an appropriate ICD-9-CM code.
CONDITIONS:	Given a DA Form 3647 or 3647-1 with the inpatient diagnosis and/or surgical procedure annotated in writing and ICD-9-CM.
STANDARDS:	The soldier must assign the code IAW ICD-9-CM.

1. Learning Step / Activity 1. General description of ICD-9-CM volumes

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-02

A. Volume 1 - tabular list of diseases and injuries (tabular meaning organized as a numerical table or list).

1. 17 chapters of main classifications

2. Types of conditions (i.e., infections, neoplasms) and anatomical systems (i.e., diseases of the digestive system)

B. Volume 2 - alphabetic index divided into sections

NOTE: Explain that volumes 1 and 2 compliment each other and will always be used as a set when coding diseases and injuries

1. Index to diseases

2. Table of drugs and chemicals

SHOW SLIDE S-HPABG002-03

C. Volume 3 - a tabular list and alphabetical index of procedures

1. Tabular List - first section, based on anatomy

2. Alphabetic Index - second section, used to locate main term/sub-term

NOTE: Never code procedures directly from the Alphabetic Index. After locating a code in the index, refer to that code in the Tabular List for important instructions.

SHOW SLIDE S-HPABG002-04

D. Conventions/Instructional Notations.

1. Abbreviations.

a. NOS - not otherwise specified (used only in volume 1).

Example: Lymphangitis, acute NOS, 682.9 (pg 459, vol 2; pg 573, vol 1).

b. NEC - not elsewhere classifiable. Term used in volumes 2 & 3 when coder lacks information necessary to code the term to a more specific category.

Example: Tobacco abuse, NEC, 305.10 (pg 714, vol 2; pg 233, vol 1).
Intra-abdominal arteriography, NEC, 88.47 (pg 308/256, vol 3).

SHOW SLIDE S-HPABG002-05

2. Punctuation.

a. ( ) - parentheses are used to enclose supplementary words which may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned (one common code).

Example: Syphilis, secondary, relapse (treated) (untreated), 091.7 (pg 701, vol 2).

b. [ ] - brackets are used to enclose synonyms, alternative wordings, or explanatory phrases.

Example: Neoplasm, bone, astragalus [talus], 170.8 (pg 497, vol 2; pg 101, vol 1).

SHOW SLIDE S-HPABG002-06

c. : - colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers which follow in order to make it assignable to a given category.

Example: Talipes: calcaneous, equinus; 754.79 (pg 669, vol 1).

SHOW SLIDE S-HPABG002-07

d. } - braces are used to enclose a series of terms, each of which is modified by the statement appearing at the right of the brace.

Example: Emphysema, (chronic), due to inhalation of chemical fumes and vapors, 506.4 (pg 269, vol 2; pg 423, vol 1).

SHOW SLIDE S-HPABG002-08

3. Instructional notations.

a. Includes: - this note appears immediately under a three-digit code title to further define, or give example of, the contents of the category.

b. Excludes: - terms following the word 'excludes' are to be coded elsewhere as indicated in each case

c. Note: - certain main terms are followed by "Note:" which is used to define terms and give coding instructions at the main 3-digit category.

d. Code also underlying disease: - this note requires that the underlying disease (etiology) be recorded first and the particular manifestation recorded secondarily. This note appears only in Volume 1 Diseases: Tabular List.

SHOW SLIDE S-HPABG002-09

e. Use additional code if desired: - this instruction is placed in the Tabular List in those categories where the coder may wish to add further information (by using additional code) to give a more complete picture of the diagnosis or procedure.

NOTE: Explain that when this note appears, ignore the 'if desired' and always use more than one code to accurately define the diagnosis.

Example: Polyneuropathy in Diabetes, 357.20 & 250.60 (pg 205, vol 2; pg 279 vol 1).

f. Section mark (see top of page xxiv, vol 1) - this symbol preceding a code denotes the placement of a footnote at the bottom of the page which is applicable to all subdivisions of that code.

Example: Delivery, malpresentation, NEC, 652.91 (pg 184, vol 2; pg 548, vol 1).

NOTE: The section mark appears preceding the major 3-digit category (652, Malposition and malpresentation of the fetus, pg 547, vol 1) therefore verification must always be taken back to the major 3-digit category in volume 1 to ensure no reference to a 5th digit requirement.

SHOW SLIDE S-HPABG002-10

4. Cross references.

a. See - an explicit direction to look elsewhere.

Example: Gastrointestinal - see condition (pg 329, vol 2).

b. See also - directs the coder to look under another main term if all the information being looked for cannot be located under the first.

Example: Gastroenteritis, acute (see also - enteritis) (pg 328, vol 2).

SHOW SLIDE S-HPABG002-11

5. Etiology and manifestation of disease - for certain conditions, it is important to record both the etiology (underlying cause) and the manifestation (significant conditions) of the disease as it is currently presented.

a. Apply a fifth digit code.

b. Both the etiology and the manifestation are coded individually (the Alphabetic Index will list both codes).

NOTE: You must trust the Alphabetic Index when you consult the Tabular List, especially since the term you locate in the index is not repeated in the Tabular List. Index guidance should always be followed unless the Tabular List gives instructions which specify otherwise.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Use the ICD-9-CM to code diagnoses and procedures

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

NOTE: Refer students to Volume 2. Explain that although the volumes are numbered, Volume 2 is always used first to begin the process of coding a disease or injury.

NOTE: Instruct students to turn to page 1, vol 2.

SHOW SLIDE S-HPABG002-12

A. Volume 2 - Index to Diseases

1. Main terms - bold print, arranged alphabetically.

a. May be the actual disease (cholecystitis, appendicitis)

b. May be the actual problem (failure, congestion, infarction, distress)

c. May never be an anatomical part or organ (heart, stomach) or a 'modifier' (acute, fetal, allergic)

2. Sub terms - normal print, indented, alphabetical order.

NOTE: Indention increases as diagnosis becomes more specific.

NOTE: Demonstrate the determination of main and sub terms (emphasize indentation) using the following diagnoses:

- Diaper rash (Rash, diaper, c-691.0, pg 620, vol 2).
- Chronic bronchitis (Bronchitis, chronic, c-491.9, pg 97, vol 2).
- Chronic bronchitis w/ airway obstruction (Bronchitis, chronic, with airway obstruction, c-491.2, pg 97, vol 2).

SHOW SLIDE S-HPABG002-13

3. Tables - used when a specific disease can be classified in more than one manner.

NOTE: Refer students to Vol 2, pg 375.

a. Hypertension - has a table following the main term. Classification columns used to identify malignant (life-threatening), benign (non-life threatening), and unspecified (not specified benign or malignant) conditions,

NOTE: Refer students to Vol 2, pg 494.

b. Neoplasms - table lists neoplasms by anatomic site, alphabetically. Columns used to further classify condition as:

1) Malignant - to include primary (cancer originated in that area first), secondary (cancer has metastasized to a second location), and carcinoma in situ (cancer has remained where it originated).

2) Benign - not malignant, not recurrent, favorable for recovery.

3) In situ - neoplasms undergoing malignant changes and still confined to the point of origin and have not yet invaded the surrounding normal tissue.

4) Uncertain behavior - ultimate behavior of neoplasm can not be determined or predicted, may undergo changes at a later date.

5) Unspecified nature - diagnosis not specifically stated by behavior or morphology and not noted as benign or malignant.

SHOW SLIDE S-HPABG002-14

B. Volume 2 - Table of Drugs and Chemicals

NOTE: Refer students to Vol 2, pg 763.

1. Contains a classification of drugs and other chemical substances to identify poisoning states and external causes (E codes) of adverse effects.

2. Department of the Army directs use of only column 1, Poisoning, and column 3, Therapeutic Use (adverse reaction).

NOTE: Therapeutic use refers to a correct substance properly administered in therapeutic or prophylactic dosage.

a. Only E codes E930 through E949 are used by the military.

NOTE: Have students determine the code for an adverse reaction to penicillin.
(E930.0, pg 834, vol 2)

b. Other cause of injury codes come from Standard NATO Agreement 2050 (STANAG 2050).

NOTE: Explain that the military has its own unique injuries (combat and training injuries), therefore, it has its own injury codes.

SHOW SLIDE S-HPABG002-15

C. Volume 1 - Tabular List of Diseases and Injuries

NOTE: Have students turn to volume 1

1. Used to verify diagnostic code found in Volume 2.

NOTE: Explain that volume 1 may provide additional instructions or notes that would direct the use of a different code from that selected in volume 2.

SHOW SLIDE S-HPABG002-16

2. Structure.

a. Chapter - groups of three digit codes referring to a broad spectrum of diseases or injuries.

Example: Chapter 1, Infectious and parasitic diseases (001-139), pg 1, vol 1.

b. Sections - groups of three digit codes that narrow down the spectrum.

Example: Intestinal Infectious Diseases (001-009), pg 1, vol 1.

c. Categories - three digit codes that represent specific information about a disease or injury group.

Example: 008 Intestinal infections due to other organisms, pg 5, vol 1.

d. Subcategories - four digit codes that represent specific information about a disease or injury.

Example: 008.4 Other specified bacteria, pg 5, vol 1.

e. Sub-classifications - five digit codes that further define a specific type of disease.

Example: 008.42 Psuedomonas, pg 5, vol 1.

NOTE: Explain that therefore, the code 008.42 is an infectious or parasitic disease, specifically of the intestines, caused by an otherwise specified bacteria, specifically Psuedomonas.

NOTE: Refer students to pg 880, vol 1.

SHOW SLIDE S-HPABG002-17

3. Supplementary Classification, V-codes. Provided to deal with occasions when circumstances other than a disease or injury classifiable to categories 001-999, or to the E code, are recorded as "diagnoses" or "problems."

a. Person not currently sick encounters the health services for some specific purpose:

1) To act as an organ donor.

Example: V59.4, Donor, kidney; (pg 912, vol 1 (pg 251, vol 2)).

2) To receive a prophylactic vaccination.

Example: V04.1, Vaccination, smallpox; (pg 883, vol 1 (pg 741, vol 2)).

b. A circumstance or problem is present which influences the person's health status but is not itself a current illness or injury. An example is a personal history of certain diseases.

NOTE: Explain that in these circumstances the V code should only be used as a supplementary code and should not be the one selected for use in primary, single cause tabulations.

Example: V01.1, contact with or exposure to tuberculosis; (pg 880, vol 1 (pg 286, vol 2)).

SHOW SLIDE S-HPABG002-18

D. Volume 3 - Tabular List and Alphabetic Index of Procedures

1. Tabular List.

a. Similar to the Tabular List found in Volume 1.

b. Contains special instructions and notes relevant to the coding of procedures.

c. Used to verify procedure codes obtained from the Alphabetic Index.

2. Alphabetic Index.

a. Used first.

b. Locate main terms and sub-terms (modifiers).

NOTE: Never code directly from the Alphabetic Index. After locating a code in the index, refer to that code in the Tabular List for important instructions. These instructions are in the form of notes suggesting the use of additional codes, and exclusion notes which indicate the circumstances under which a procedure would be coded elsewhere.

Example: Appendectomy, incidental; 47.1, pg 307/131, vol 1.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	Complete the required fields of a DA Form 3647.
CONDITIONS:	Given a DA Form 3647, the IPDS User's Manual, a DA Form 2985, AR 40-66, and AR 40-400.
STANDARDS:	The soldier must complete the required fields IAW AR 40-66, AR 40-400, and IPDS User's Manual.

1. Learning Step / Activity 1. Purpose/preparation of DA Form 3647

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-19

A. Purpose of Inpatient Record Cover Sheet (DA Form 3647/3647-1).

1. Provides administrative and medical summary of each inpatient episode.

2. An essential document for a Health Record, Outpatient Record, and ITR.

3. Source document for statistical information.

B. Prepared by:

1. All hospitals.

2. Fixed troop clinics.

3. Convalescent centers.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Reasons for preparation and distribution or DA Form 3647

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-20

A. Prepared for:

1. All admissions (for bed care).

2. Liveborn (not prepared for still births).

3. Carded for Record Only (CRO).

a. Death (DOA at your facility).

b. Disability separation/retirement (Medical Boards processed on an outpatient basis.

c. Selected conditions of medico-legal significance (to provide a record for MTF, i.e., rape or assault cases).

SHOW SLIDE S-HPABG002-21

B. Distribution of DA Form 3647.

1. Original and worksheet - Inpatient Treatment Record.

2. 1 copy - Health Record or Outpatient Record as applicable.

NOTE: Need for extra copies may vary depending on MTF policy.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Completing the DA Form 3647

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44

Media: PRINT

NOTE: Explain that items 1-24, 27-30, and 33 are completed at the time of admission.

SHOW SLIDE S-HPABG002-22

A. Item 25 - Type of Disposition.

1. Duty - active duty personnel only.

2. Transfer - any category of patient.

    a. Enter "TAR" if transferred to Army MTF.

    b. Enter "TAF" if transferred to Air Force MTF.

    c. Enter "TNV" if transferred to Navy MTF.

    d. Entry must begin in Item 25 and continued in Item 31, stating the name of the facility the patient was transferred out to.

3. Separation/retirement under provisions of AR 635-40 or AR 635-200.

    a. Enter "PDRL" or "TDRL" AR 635-40 (Permanent or Temporary Disability Retirement).

    b. Separation and action taken (i.e., severance pay), for AR 635-200 separations.

4. Discharged - non-active duty patients.

5. Death (hospital, CRO, neonatal, or maternal).

    a. Enter "Died" or "Expired."

    b. Continue in Item 31 whether an autopsy was done (i.e., "Autopsy Yes" or "Autopsy No").

SHOW SLIDE S-HPABG002-23

B. Item 26 - Date of disposition.

1. DD MMM YY - This will be the date the patient's name appeared on the AAD report as a disposition.

2. CRO records - date of disposition is same as date of admission (Item 28).

SHOW SLIDE S-HPABG002-24

C. Item 31 - Administrative data.

1. Medical and Physical Evaluation Boards.

a. Enter type of board (MEB, PEB).

b. Enter date of board.

c. Enter recommendations made by board.

2. Absence of patient - enter dates from and to, enter total number of days in parentheses.

a. Other days - total number of days spent in 'status-out' to :

1) AWOL (more than 10 consecutive days only).

2) PCS home.

3) PCS VA.

4) Subsisting out.

5) TDY

6) Other authorized absence (i.e., leave).

b. Absent sick - enter hospital and dates from and to.

c. Supplemental care days - enter place and dates from and to.

d. Convalescent leave - enter dates from and to.

3. ASMRO (Armed Services Medical Regulating Office)

a. If patient was evacuated (coordinated through ASMRO), enter the ASMRO cite number authorizing the movement.

b. Enter the cite movement precedence (Urgent/Priority/Routine) and the name of the physician accepting the patient at the receiving MTF.

4. SI/VSI patients.

a. Enter a clear chronological outline of patient's status.

b. Show dates patient was placed on and taken off the SI/VSI roster.

NOTE: This is for progress reporting purposes and eliminates the need for the receiving MTF to search through the patient's record for this information.

5. Neonatal death.

a. Death of an infant under 28 days of age.

b. Enter the infant's age at death.

Example: Neonatal death age - 15 days.

NOTE: If the death occurred during the first 24-hours, enter the age in hours.

6. Change of status date.

Example: Newborn to pay status when the infant remains and the mother is discharged.

SHOW SLIDE S-HPABG002-25

D. Item 32 - Units of Whole Blood transfused.

1. Enter number of units (500cc = 1 unit)

2. If no blood transfused, leave blank.

SHOW SLIDE S-HPABG002-26

E. Item 33 - Cause of Injury.

1. Complete only for patients treated for injuries.

NOTE: The Type Case (Item 20) will be either INJ or BC for patients admitted with an injury. Injury occurring after admission (drug reaction, fall from bed, etc.) will require a cause of injury code and statement.

2. External cause of injury (specify poison, chemical reaction).

3. Circumstances and activity - how the injury occurred.

a. Action against enemy.

b. Activity (patient's actions).

1) Accidentally incurred (rifle accidentally discharged while cleaning).

2) Deliberately incurred.

a) Inflicted by another person.

b) Self-inflicted to avoid duties or as an act of the mentally unsound (suicide or attempted suicide).

c. Motor vehicle accident.

1) Enter type of vehicle (car, bus, truck).

2) Enter ownership of vehicle (POV, GOV).

d. Location (place).

1) On post (barracks, mess hall, etc.).

2) Off post (state specific location).

e. Date and time of injury.

f. Duty status of military member at time of injury.

1) Engaged in assigned duties and their nature.

2) AWOL.

3) Pass.

4) Leave.

NOTE: This information is important for Medical Affirmative Claims, Line of Duty investigations, and Medical Evaluation Boards.

SHOW SLIDE S-HPABG002-27

F. Item 34 - Diagnoses and Operations.

1. Diagnoses.

a. Number consecutively when recording more than one diagnosis.

1) Enter the principle diagnosis first when more than one diagnosis exists.

NOTE: Principle diagnosis determination is the responsibility of the physician. This diagnosis is established after study to be chiefly responsible for this admission. Do not record diagnoses from past admissions, status post conditions, or physical findings that have no bearing on the current period of treatment.

2) For patients whose entire episode was in Absent Sick status, all diagnoses treated and procedures performed will be entered by the recording MTF.

b. Enter code number to left of medical terminology.

c. Enter diagnosis in medical terminology.

d. Enter any additional administrative information needed to fully define the diagnosis.

1) Enter "EPTS" if the diagnosis existed prior to service.

2) Enter "PR" if the condition relates to a previously treated condition (active duty patients only), then enter date and place.

Example: 493.90 Asthma (PR WRAMC WASH DC Jan 98)

3) Document Residual Disability (include body part).

NOTE: This applies to an injury causing separation or retirement determined during the current hospital stay.

Example: Limb amputation - duty impairment.

4) Document Death information.

a) Diagnosis determined after death will be identified as "Established Post Mortem."

b) Suicide, homicide, or legal execution.

c) Enter "Underlying Cause" of death if applicable.

e. Deliveries (Mother's Record).

1) Presentation of fetus (breech, face, etc.).

2) Liveborn or stillbirth.

3) Duration of pregnancy in weeks.

4) Previous cesarean section (if any).

5) If still birth cause of fetal death and birthweight must be recorded on mother's record.

NOTE: Information required for a stillbirth is part of the mother's record. A separate record is not made for the stillborn child.

2. Operations/Procedures.

a. Enter date procedure took place.

b. Enter principal procedure code.

NOTE: The principal procedure determination is the responsibility of the physician. This procedure is the one performed for definitive treatment most closely related to the principal diagnosis (removal of cancer of the tongue), rather than for diagnostic biopsy or exploratory purposes; or, to treat a complication such as a fall necessitating surgical fixation of a broken hip; or most tissue removed; or tests done for the procedure most related to the principal diagnosis or a therapeutic procedure.

c. Enter procedural terminology.

SHOW SLIDE S-HPABG002-28

G. Item 35 - Total Days this Facility.

NOTE: This item refers to the medical treatment facility where the coversheet is being completed.

SHOW SLIDE S-HPABG002-29

1. Item 35a - Absent Sick days.

    a. Cross reference Item 31 for number of days.

    b. No days recorded in Item 31, leave Item 35a blank.

SHOW SLIDE S-HPABG002-30

2. Item 35b - Other days.

NOTE: This could relate to a patient en route from one facility to another, AWOL, PCS home, PCS VA, TDY, or other authorized absence, but out-of-the-bed at government cost (active duty).

SHOW SLIDE S-HPABG002-31

3. Item 35c - Convalescent Leave/Cooperative Care days.

    a. Cross reference Item 31.

    b. If no Conv Lv/Coop Care, leave blank.

SHOW SLIDE S-HPABG002-32

4. Item 35d - Supplemental Care days.

NOTE: Patients must be in Status-Out receiving care or having a need for equipment at another facility during hospitalization.

    a. Cross Reference Item 31.

    b. If no supplemental care days, leave blank.

SHOW SLIDE S-HPABG002-33

5. Item 35f - Total Sick days.

NOTE: It is necessary to know the total sick days before Bed days (Item 35e) can be calculated.

    a. Subtract date of this admission from the date of disposition (use Julian dates).

    b. Verify that the total number of days (35f) is equal to the sum of 35a thru 35e.

c. Absent sick patients: subtract date of initial admission from disposition date.

SHOW SLIDE S-HPABG002-34

6. Item 35e - Bed days.

    a. Days recorded in 35a thru 35d are not bed days.

    b. Days occupying a bed or bassinet.

    c. Enter 0 in Item 35f for CRO or total absent sick patients.

SHOW SLIDE S-HPABG002-35

H. Item 36 - Total Days All Facilities.

NOTE: This is used for Transfer Admissions only. Verify this from Item 21, Source of Admission.

1. Summation of all transfer ITRCS days.

2. Leave blank for direct admissions.

3. Subtract date of initial admission from date of disposition.

    a. Item 36a - Absent sick days.

    b. Item 36b - Other days.

    c. Item 36c - Con Lv/Coop Care days.

    d. Item 36d - Supplemental Care days.

    e. Item 36e - Bed days.

    f. Item 36f - Total sick days.

    NOTE: Days to be recorded in Item 36a thru 36f can be determined by cross referencing Item 31 of all ITRCS received from other facilities.

SHOW SLIDE S-HPABG002-36

I. Signature blocks are typed as required.

1. Attending physician, dentist, podiatrist, or midwife will sign worksheet copy.

2. Signature of attending physician is not required on CRO cases (patient did not occupy bed).

3. Patient or Medical Record Administrator (name, grade, corps - all caps).

a. Signs all completed ITRCS.

b. Only signature required for CRO and DOA cases.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	Assign an appropriate CPT4 code.
CONDITIONS:	Given an Ambulatory Data System (ADS) encounter form with the diagnosis and/or ambulatory procedure annotated in writing and CPT4.
STANDARDS:	The soldier must assign the code IAW CPT4.

1. Learning Step / Activity 1. Describe the use of CPT codes.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-37 (Show this slide while discussing the ELO Title)

SHOW SLIDE S-HPABG002-38

A. Description. Current Procedural Terminology (CPT) is a systematic listing of procedures and services performed by physicians. Each procedure or service is identified by a five digit code.

1. Provides a uniform language that accurately describes medical, surgical and diagnostic services.

2. Provides reliable communication between physicians, patients and third parties.

SHOW SLIDE S-HPABG002-39

B. Use.

NOTE: CPT Codes are used to report outpatient procedures and services **only**.

1. Insurance billing for procedures and services provided.

2. Administrative management purposes (i.e., claims processing).

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Describe the format of the CPT book.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-40

A. The Physician's Current Procedural Terminology (CPT) is divided into three main parts.

1. Main Text.

2. Appendices.

3. Alphabetic Index.

SHOW SLIDE S-HPABG002-41

B. Main Text.

1. Divided into six sections.

a. Evaluation and Management.

NOTE: Items in this section will be used by most physicians to report a significant portion of their services.

b. Anesthesiology.

c. Surgery.

d. Radiology (including Nuclear Medicine and Diagnostic Ultrasound).

e. Pathology and Laboratory.

f. Medicine.

NOTE: Listing a service or procedure and it's code number in a specific section of the book does not limit it's use to a specific specialty group. Any procedure or service in any section of the book may be performed by any qualified individual.

SHOW SLIDE S-HPABG002-43

2. Subsections. Divide main sections and contain anatomic, procedural, condition or descriptor subheadings.

Example: pg 127, Respiratory (main section), Nose (subsection), Incision (procedural subheading).

3. Format of CPT procedure terminology.

a. Developed as stand-alone descriptions of medical procedures.

b. Some procedures refer back to a common portion of the procedure listed in a preceding entry. This is evident when a procedure is followed by one or more indentations.

Example: pg 95, 25105 Arthrotomy, wrist joint; for synovectomy

NOTE: The common part of code 25100 (the part before the semicolon) should be considered part of code 25105.

SHOW SLIDE S-HPABG002-44

C. Four Appendices.

1. Appendix A - Modifiers. Contains a list of all modifiers applicable to CPT codes.

NOTE: Explain that modifiers are used to indicate a service or procedure that has been performed has been altered by some specific circumstance but has not been changed in its definition or code.

2. Appendix B - Summary of Additions, Deletions or Revisions.

3. Appendix C - Update to Short Descriptors. Used to update electronic (digital) CPT data file.

4. Appendix D - Clinical Examples Supplement. Provides examples of clinical encounters with patients that would be coded under the Evaluation and Management section of the CPT.

NOTE: The examples contained in Appendix D are not to be used to code the encounter.

SHOW SLIDE S-HPABG002-45

D. Index.

1. Main Terms. The index is organized by main terms arranged alphabetically in 4-primary classes.

a. Procedure or service.

Example: Endoscopy, Anastomosis; Splint.

b. Organ (or other anatomic site).

Example: Tibia; Colon; Salivary Gland.

c. Condition.

Example: Abcess; Entropian; Tetralogy of Fallot.

d. Synonyms, Eponyms, and Abbreviations.

Example: EEG; Bricker Operation; Clagett Procedure.

SHOW SLIDE S-HPABG002-46

2. Conventions.

a. Modifying Terms.

1) Indented.

2) Up to 3 may follow main term.

NOTE: When modifying sub-terms appear, review list. Sub-terms effect selection of appropriate code.

b. Code Ranges.

1) Used whenever more than one code applies.

2) Two sequential or several non-sequential, separated by comma.

Example: pg 432, 69220, 69222; Debridement, Mastoid Cavity

3) More that two sequential, separated by hyphen.

Example: pg 407, 86060-86063; Antibody, Antistreptolysin 0.

SHOW SLIDE S-HPABG002-47

c. Cross References.

1) See: - Directs the coder to the term listed after the word "See." Used primarily for synonyms, eponyms, and abbreviations.

2) See Also: - Directs the coder to look under another main term if the procedure is not listed under the first main term entry.

NOTE: The index is **not** a substitute for the main text of CPT. The user must refer to the main text to ensure accurate code selection.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Describe the ADS encounter form.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-48

A. General.

1. Backbone of the Ambulatory Data System (ADS).

NOTE: The ADS is a system by which detailed, patient-level information on outpatient care provided by the Military Health Services System (MHSS) is collected.

2. "Bubble Sheet" - similar to those used when taking a test.

3. Prepared in advance for all patients with scheduled appointments.

B. Sections.

SHOW SLIDE S-HPABG002-49

1. Front side.

a. ICD-9-CM Diagnoses - a pick list of diagnoses most common to the clinic.

NOTE: The diagnoses listed in this section will vary from clinic to clinic based on the type of medicine practiced.

b. Evaluation & Management.

1) Correlates to E&M section of CPT Manual.
2) Lists most common E&M codes for the clinic.

SHOW SLIDE S-HPABG002-50

c. Disposition.

d. Administrative.

e. Appointment Status.

SHOW SLIDE S-HPABG002-51

f. CPT Procedures - lists the most common procedures performed in the clinic.

NOTE: The procedures listed in this section will vary from clinic to clinic based on the type of medicine practiced.

g. Patient identification/demographic information.

SHOW SLIDE S-HPABG002-52

2. Back side.

a. Other Diagnoses - space for entering up to three diagnoses, and CPT codes, that are not contained in the pick list on the front of the form.

b. Other Procedures/E&M - space for entering up to three procedures or E&M descriptions, and the correlating codes, that are not listed on the front of the form.

c. Other information.

1) Third party insurance information.
2) Provider/additional provider information.
3) Patient demographic changes.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Code a diagnosis or procedure in an outpatient record.

Method of Instruction: Conference / Discussion
Instructor to Student Ratio: 1:44
Media: PRINT

SHOW SLIDE S-HPABG002-53

NOTE: As stated earlier, the most common procedures performed in the clinic will be noted in the pick list on the front of the ADS encounter form. However, for our purposes we will assume that the diagnosis and procedure are annotated on the back of the form, and need to be coded.

SHOW SLIDE S-HPABG002-54

Scenario: A patient is seen in the clinic for a dressing change and debridement with anesthesia of a 3rd degree burn suffered to the forearm and hand (less than 9% BSA, full thickness). (ICD-9-CM, V58.3; Aftercare, change of dressings)
(E&M, 99214)

NOTE: The Evaluation and Management (E&M) code is required for all patients. The healthcare provider is held accountable for this code and must attest to its accuracy.

SHOW SLIDE S-HPABG002-55

A. Code the diagnosis, using the ICD-9-CM, IAW the method described previously.

B. Locate the code for the procedure in the CPT manual.

1. Using the main text.

SHOW SLIDE S-HPABG002-56

a. Carefully read the description of the procedure from the clinical documentation provided - dressing change and debridement with anesthesia, forearm and hand.

SHOW SLIDE S-HPABG002-57

b. Determine which section of the main text to look in (i.e., Surgery, Anesthesia, etc.). Carefully read the guidelines for that section.

Example: Surgery

1) Determine the appropriate subdivision (body region or system).
Example: Integumentary, Repair, Burns, Local Treatment

2) Determine the appropriate code for the procedure or service.
Example: 16015, Dressings and/or debridement, initial or subsequent; under anesthesia, medium or large, or with major debridement.

SHOW SLIDE S-HPABG002-58

2. Using the index.

a. The index is an alphabetic listing of anatomical locations/regions, body systems, procedures and services.

b. Locate procedure or service and note the code to the right.

NOTE: Do not assign the code based solely on the listing in the index.

c. Refer to the main text for a detailed description of the procedure or service and assign the appropriate code as explained above.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. SUMMARY

Method of Instruction: Conference / Discussion

Instructor to Student Ratio is: 1:44
Time of Instruction: 0 hrs
Media: PRINT

Review / Summarize Lesson

SHOW SLIDE S-HPABG002-59

During this lesson we have discussed the methods used to convert the medical terminology used in describing a patient's diagnosis and the treatment (procedures/services) received by the patient, into standardized numerical codes.

We have discussed the ICD-9-CM, used to code Inpatient Records; and the Inpatient Treatment Record Coversheet, which becomes the source document for any possible billing for inpatient treatment and/or statistical applications. And, we have discussed the use of Current Procedural Terminology (CPT) to code outpatient records.

It is important to remember, that although procedures and services are provided to both inpatients and outpatients in the MTF, these procedures and services are coded differently based on the patient's status (in/outpatient).

Check on Learning

Conduct a check on learning and summarize the lesson.

SECTION V. STUDENT EVALUATION

Testing Requirements

NOTE: Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.

Feedback Requirement

NOTE: Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

PRACTICAL EXERCISE SHEET PE1-HPABG002

Title

Assign a CPT4 Code

Lesson Number/Title

HPABG002 version 1 / Diagnostic/Procedural Coding

Introduction

Motivator

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Select the correct alphabetical/numerical diagnostic and/or procedural code.
Conditions:	Given DA Form 2985, Admission and Coding Information, medical terms, and surgical procedures; DA Form 3647, Inpatient Treatment Record Coversheet; ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification; and Inpatient Data System (IPDS) User's Manual ; a completed Ambulatory Encounter Summary with ambulatory procedures; CPT4, Current Procedural Terminology 4th Revision; AR 40-66, Medical Record Administration; AR 40-400, Patient Administration.
Standards:	Select the correct alphabetical/numerical diagnostic and/or procedural codes IAW the ICD-9-CM, CPT4, DA Form 3647, AR 40-66, AR 40-400, and IPDS User's Manual.

Safety Requirements

Risk Assessment Level

Low

Environmental Considerations

Evaluation

Instructional Lead-In

Resource Requirements	Instructor Materials: Student Materials: M-HPABG002, Student Handout ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification CPT4, Common Procedural Terminology, 4th Revision PE1-HPABG002, Assign a CPT4 Code PE2-HPABG002, Assign an ICD-9-CM Code PE3-HPABG002, Complete a DA Form 3647
Special Instructions	
Procedures	
Feedback Requirements	

PRACTICAL EXERCISE SHEET PE2-HPABG002

Title

Assign an ICD-9-CM Code

Lesson Number/Title

HPABG002 version 1 / Diagnostic/Procedural Coding

Introduction

Motivator

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Select the correct alphabetical/numerical diagnostic and/or procedural code.
Conditions:	Given DA Form 2985, Admission and Coding Information, medical terms, and surgical procedures; DA Form 3647, Inpatient Treatment Record Coversheet; ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification; and Inpatient Data System (IPDS) User's Manual ; a completed Ambulatory Encounter Summary with ambulatory procedures; CPT4, Current Procedural Terminology 4th Revision; AR 40-66, Medical Record Administration; AR 40-400, Patient Administration.
Standards:	Select the correct alphabetical/numerical diagnostic and/or procedural codes IAW the ICD-9-CM, CPT4, DA Form 3647, AR 40-66, AR 40-400, and IPDS User's Manual.

Safety Requirements

Risk Assessment Level

Low

Environmental Considerations

Evaluation

Instructional Lead-In

Resource Requirements

Instructor Materials:

Student Materials:
M-HPABG002, Student Handout
ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification
CPT4, Current Procedural Terminology, 4th Revision
PE2-HPABG002, Assign an ICD-9-CM Code

Special Instructions

Procedures

Using Volumes 1, 2, & 3 of ICD-9-CM, code the following inpatient diagnoses and procedures IAW the methods discussed in the lesson.

Working with Main Terms

Annotate the volume number, page number(s), and code for each of the following:

1. Obesity
2. Low back pain
3. Hepatitis
4. Viral Syndrome
5. Acute diarrhea
6. Juvenile diabetes (controlled)
7. Painful respiration
8. Upward gaze syndrome
9. Inflammatory diarrhea due to specified organism NEC
10. Diabetic ketosis, juvenile type
11. Chronic childhood schizophrenia
12. Periostitis of the wrist

Working with Injuries

13. Third degree burns, multiple sites of the trunk

14. Sprain of the tibia, distal end

15. Gunshot wound to the chest wall, complicated

16. Cervical spinal (cord) injury, level C5-C7

17. Nonvenomous insect bite, to the left index finger, infected

18. Traumatic amputation of the right leg, above the knee

19 Stabbing wound to thigh, with injury to femoral artery

20. Stellate lacerations of the liver

21. Closed fracture of second cervical vertebra

22. Open wound, multiple sites of upper limb, with tendon involvement

Working with External Causes of Injury Codes - E Codes

Remember, not all "E Codes" are preceded by the "E" character. Use only the poisoning and therapeutic columns.

WHAT IS THE PROBLEM? WHAT CAUSED THE PROBLEM? WAS IT A POISONING OR AN ADVERSE REACTION (THERAPUTIC USE)?

23. Tachycardia, due to adverse reaction to Benadryl

24. Charcoal fumes poisoning

25. Inflammation of the throat due to rubbing alcohol ingestion

26. Toxic gastroenteritis and colitis due to soap powder poisoning

27. Superficial skin swelling due to tetanus toxoid vaccination

Working with Dual Codes

28. Hepatitis due to malaria

29. Diabetic neuralgia (adult onset)

30. Rheumatic pneumonia

31. Abscess of the epididymis due to streptococcus bacteria infection

32. Neoplasm of the esophagus primary, with metastasis to the larynx secondary

Miscellaneous

33. Carcinoma of the brain, frontal lobe

34. Hypertension due to kidney calculus, benign

35. Psychosexual dysfunction with frigidity

36. Vitamin D deficiency with rickets

37. Postoperative hernia with obstruction

38. Foreign body inadvertently left in operative wound, causing adhesions

39. Acute gastritis with hemorrhage

40. Otitis Media, Acute, mucoid

41. Chronic gonoccal prostatitis

42. Labor, undelivered

Working with V-Codes

43. Artificial insemination

44. Family history of leukemia

45. Holiday relief care

46. Bone marrow donor

47. Admission for adjustment of artificial eye

48. Traction maintenance, NEC

49. Marital adjustment involving estrangement

50. Admission for sterilization, male

51. Prophylactic smallpox vaccination

PROCEDURES

Working with Main Terms

52. X-ray of the chest wall

53. Plasma transfusion

54. Tenotomy of the stapedius

55. Total resection of the esophagus

56. Steinberg operation

57. Exploratory pelvic laparotomy

58. Repair of lacerated liver

59. Hypodermic injection of therapeutic agent into the bursa of the hand

60. Removal of foreign body from the nailbed, left thumb

61. Mid-forceps delivery, with episiotomy

62. Correction of lop ear

63. Face lift

64. Electrocoagulation of cervical lesion

65. Biopsy of ocular muscle

66. Circulation time function study

67. Repair of open fracture of foot with internal fixation

68. Tenoplasty of left hand by implant

69. Removal of impacted feces
70. Corneal irrigation with removal of foreign body
71. Replacement of nasogastric tube
72. Application of fiberglass cast to upper limb
73. Reinsertion of internal fixation device of the fibula
74. Umbilical herniorrhaphy
75. Thrombectomy of a femoral vein
76. Root canal with irrigation

Working with Dual Coded Procedures

77. Partial esophagectomy with thoracic esophagostomy
78. Laryngoscopy with biopsy
79. Reattachment of left thumb and right index finger
80. Fistulectomy of the small and large intestine

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 2

Using Volumes 1, 2, & 3 of ICD-9-CM, code the following inpatient diagnoses and procedures IAW the methods discussed in the lesson.

Working with Main Terms

Annotate the volume number, page number(s), and code for each of the following:

1. Obesity

2. Low back pain

3. Hepatitis

4. Viral Syndrome

5. Acute diarrhea

6. Juvenile diabetes (controlled)

7. Painful respiration

8. Upward gaze syndrome

9. Inflammatory diarrhea due to specified organism NEC

10. Diabetic ketosis, juvenile type

11. Chronic childhood schizophrenia

12. Periostitis of the wrist

Working with Injuries

13. Third degree burns, multiple sites of the trunk

14. Sprain of the tibia, distal end

15. Gunshot wound to the chest wall, complicated

16. Cervical spinal (cord) injury, level C5-C7

17. Nonvenomous insect bite, to the left index finger, infected

18. Traumatic amputation of the right leg, above the knee

19 Stabbing wound to thigh, with injury to femoral artery

20. Stellate lacerations of the liver

21. Closed fracture of second cervical vertebra

22. Open wound, multiple sites of upper limb, with tendon involvement

Working with External Causes of Injury Codes - E Codes

Remember, not all "E Codes" are preceded by the "E" character. Use only the poisoning and therapeutic columns.

WHAT IS THE PROBLEM? WHAT CAUSED THE PROBLEM? WAS IT A POISONING OR AN ADVERSE REACTION (THERAPUTIC USE)?

23. Tachycardia, due to adverse reaction to Benadryl

24. Charcoal fumes poisoning

25. Inflammation of the throat due to rubbing alcohol ingestion

26. Toxic gastroenteritis and colitis due to soap powder poisoning

27. Superficial skin swelling due to tetanus toxoid vaccination

Working with Dual Codes

28. Hepatitis due to malaria

29. Diabetic neuralgia (adult onset)

30. Rheumatic pneumonia

31. Abscess of the epididymis due to streptococcus bacteria infection

32. Neoplasm of the esophagus primary, with metastasis to the larynx secondary

Miscellaneous

33. Carcinoma of the brain, frontal lobe

34. Hypertension due to kidney calculus, benign
35. Psychosexual dysfunction with frigidity

36. Vitamin D deficiency with rickets

37. Postoperative hernia with obstruction

38. Foreign body inadvertently left in operative wound, causing adhesions

39. Acute gastritis with hemorrhage

40. Otitis Media, Acute, mucoid

41. Chronic gonoccal prostatitis

42. Labor, undelivered

Working with V-Codes

43. Artificial insemination

44. Family history of leukemia

45. Holiday relief care

46. Bone marrow donor

47. Admission for adjustment of artificial eye

48. Traction maintenance, NEC

49. Marital adjustment involving estrangement

50. Admission for sterilization, male

51. Prophylactic smallpox vaccination

PROCEDURES

Working with Main Terms

52. X-ray of the chest wall

53. Plasma transfusion
54. Tenotomy of the stapedius
55. Total resection of the esophagus
56. Steinberg operation
57. Exploratory pelvic laparotomy
58. Repair of lacerated liver
59. Hypodermic injection of therapeutic agent into the bursa of the hand
60. Removal of foreign body from the nailbed, left thumb
61. Mid-forceps delivery, with episiotomy
62. Correction of lop ear
63. Face lift
64. Electrocoagulation of cervical lesion
65. Biopsy of ocular muscle
66. Circulation time function study
67. Repair of open fracture of foot with internal fixation
68. Tenoplasty of left hand by implant
69. Removal of impacted feces
70. Corneal irrigation with removal of foreign body
71. Replacement of nasogastric tube
72. Application of fiberglass cast to upper limb
73. Reinsertion of internal fixation device of the fibula
74. Umbilical herniorrhaphy
75. Thrombectomy of a femoral vein

76. Root canal with irrigation

Working with Dual Coded Procedures

77. Partial esophagectomy with thoracic esophagostomy

78. Laryngoscopy with biopsy

79. Reattachment of left thumb and right index finger

80. Fistulectomy of the small and large intestine

PRACTICAL EXERCISE SHEET PE3-HPABG002

Title

Complete a DA Form 3647

Lesson Number/Title

HPABG002 version 1 / Diagnostic/Procedural Coding

Introduction

Motivator

As stated in the lesson, the DA Form 3647, Inpatient Treatment Record Coversheet, serves a variety of uses. As a source document for Inpatient billing and statistical information, accuracy in preparation of this form is essential.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Select the correct alphabetical/numerical diagnostic and/or procedural code.
Conditions:	Given DA Form 2985, Admission and Coding Information, medical terms, and surgical procedures; DA Form 3647, Inpatient Treatment Record Coversheet; ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification; and Inpatient Data System (IPDS) User's Manual ; a completed Ambulatory Encounter Summary with ambulatory procedures; CPT4, Current Procedural Terminology 4th Revision; AR 40-66, Medical Record Administration; AR 40-400, Patient Administration.
Standards:	Select the correct alphabetical/numerical diagnostic and/or procedural codes IAW the ICD-9-CM, CPT4, DA Form 3647, AR 40-66, AR 40-400, and IPDS User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This exercise will evaluate your ability to accurately prepare the DA Form 3647.

Resource Requirements

Instructor Materials:
DA Form 3647, Inpatient Treatment Record Coversheet - partially completed IAW the three scenarios.

Student Materials:
M-HPABG002, Student Handout
ICD-9-CM, International Classification of Diseases, 9th Revision, Clinical Modification
CPT4, Common Procedural Terminology, 4th Revision
PE3-HPABG002, Complete a DA Form 3647

Special Instructions

Procedures

Using the DA Forms 3647 provided by your instructor, complete the form (items 25, 26, 31 thru 36f as applicable) for each of the scenarios below.

Scenario 1: ODOM, ARCHIE C. The patient was returned to duty 31 Jan 9x. During this hospitalization, he was treated for VIRAL BRONCHOPNEUMONIA (480.9); AND ASTHMA (493.90) (PR: WRAMC, Wash, D.C., 1 May 1966. Patient received 2-units of blood and was treated with a Fiberoptic Bronchoscopy (332.2) on 29 Jan 9x.

Scenario 2: BEBAK, FRANCIS J. The patient was treated for Charcot's Arthritis, (094.0, 713.5); a condition that existed prior to entering the military (EPTS). This condition had been previously recorded at WRAMC, Washington, D. C., 19 Dec 8x. During hospitalization, the case was referred to a MEB. On 23 Jan 9x the MEB met and referred his case to a PEB. The PEB met on 28 Jan 9x and recommended TDRL (temporary disability retirement list) for PVT Bebak. He went on convalescent leave from 24 to 27 Jan 9x. Effective 3 Feb 9x, Bebak was dispositioned to TDRL under provisions of AR 635-40.

Scenario 3: KAZAKOS, NICKOLAS P. While visiting his family in San Marcos, TX, the patient became ill and was admitted to HAYS COUNTY MEMORIAL HOSPITAL, SAN MARCOS, TX. He was ABSENT SICK in that facility 2 Jan 9x to 5 Jan 9x. On 5 Jan 9x he was transported to USAH Ft. Splendid, TX. After his arrival at USAH Ft. Splendid, he was diagnosed with an ULCER OF DUODENUM, WITH HEMORRHAGE (532.40); and ACUTE NORMOCYTIC ANEMIA, DUE TO BLOOD LOSS (285.1). Patient underwent a Gastric Freezing procedure (963.2)

on 6 Jan and 8 Jan 9x. He received 4 units of whole blood, and on 6 Jan 9x he was placed on the SI roster. He remained on the SI roster until 10 Jan 9x and was removed from the SI roster on 11 Jan 9x. Kazoka was then permitted to go on convalescent leave from 12 Feb 9x to 22 Feb 9x. On his return from convalescent leave however, he suffered a relapse and was transferred to BAMC, Ft. Sam Houston, TX on 23 Feb 9x.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 3

Using the DA Forms 3647 provided by your instructor, complete the form (items 25, 26, 31 thru 36f as applicable) for each of the scenarios below.

Scenario 1: ODOM, ARCHIE C. The patient was returned to duty 31 Jan 9x. During this hospitalization, he was treated for VIRAL BRONCHOPNEUMONIA (480.9); AND ASTHMA (493.90) (PR: WRAMC, Wash, D.C., 1 May 1966. Patient received 2-units of blood and was treated with a Fiberoptic Bronchoscopy (332.2) on 29 Jan 9x.

Scenario 2: BEBAK, FRANCIS J. The patient was treated for Charcot's Arthritis, (094.0, 713.5); a condition that existed prior to entering the military (EPTS). This condition had been previously recorded at WRAMC, Washington, D. C., 19 Dec 8x. During hospitalization, the case was referred to a MEB. On 23 Jan 9x the MEB met and referred his case to a PEB. The PEB met on 28 Jan 9x and recommended TDRL (temporary disability retirement list) for PVT Bebak. He went on convalescent leave from 24 to 27 Jan 9x. Effective 3 Feb 9x, Bebak was dispositioned to TDRL under provisions of AR 635-40.

Scenario 3: KAZAKOS, NICKOLAS P. While visiting his family in San Marcos, TX, the patient became ill and was admitted to HAYS COUNTY MEMORIAL HOSPITAL, SAN MARCOS, TX. He was ABSENT SICK in that facility 2 Jan 9x to 5 Jan 9x. On 5 Jan 9x he was transported to USAH Ft. Splendid, TX. After his arrival at USAH Ft. Splendid, he was diagnosed with an ULCER OF DUODENUM, WITH HEMORRHAGE (532.40); and ACUTE NORMOCYTIC ANEMIA, DUE TO BLOOD LOSS (285.1). Patient underwent a Gastric Freezing procedure (963.2) on 6 Jan and 8 Jan 9x. He received 4 units of whole blood, and on 6 Jan 9x he was placed on the SI roster. He remained on the SI roster until 10 Jan 9x and was removed from the SI roster on 11 Jan 9x. Kazoka was then permitted to go on convalescent leave from 12 Feb 9x to 22 Feb 9x. On his return from convalescent leave however, he suffered a relapse and was transferred to BAMC, Ft. Sam Houston, TX on 23 Feb 9x.

PART G: MAINTENANCE OF MEDICAL REGULATING (MEDREG) TRANSACTION FILES

The Army developed a training program to instruct personnel on the collection and maintenance of database files containing information on medical facilities. Such information is important, as patients should be referred only to facilities capable of providing the necessary care. Specific information in these databases may include bed status, surgical backlog, and basic unit information. The training program covers maintenance of such data files and methods for archiving the data.

Although the Army developed the training materials, the content is equally applicable and usable throughout the Military Health System.

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG72D
TSP Title	Maintenance of Medical Regulating (MEDREG) Transaction Files
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for:

This TSP
Contains

TABLE OF CONTENTS

HPABG72D version 1 / Maintenance of MEDREG Transaction Files
28 May 1998

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
6-8-C42	AMEDD NCO Advanced (NCOES)
6-8-C42 (RC)	AMEDD NCO Advanced (NCOES) Reserve Component Course Management Plan

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0320	Maintain Facility Status Using MEDREG
081-866-0321	Maintain Unit Information Using MEDREG
081-866-0322	Maintain Select Tables using MEDREG
081-866-0323	Maintain Historical Data Using MEDREG.

Academic Hours

The Academic hours required to teach this TSP are as follows:

	ADT Hours/Methods
	2.0 / Demonstration
Test	0.0 /
Test Review	0.0 /
Total Hours:	2.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
None	

Clearance Access

Security Level : Unclassified
Requirements : There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
AISM 25-HKE-RZR-ECC-UM	Automated Information Systems Manual; MEDREG HKE 04-02.A; User Manual	26 Aug 1996	

Student Study Assignments

None

Instructor Requirements

One (1) MOS 71G, MEDREG Qualified Instructor

Additional Personnel Requirements	None

Equipment Required for Instruction

Name	Quantity	Expendable
Commercial-Off-The-Shelf (COTS) System	0	No

Materials Required	Instructor Materials: None Student Materials: None
Classroom, Training Area, and Range Requirements	

Ammunition Requirements

Name	Student Qty	Misc Qty
None		

Instructional Guidance	**NOTE:** Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material.

Proponent Lesson Plan Approvals

Name	Rank	Position	Date

SECTION II. **INTRODUCTION**

Method of Instruction: Demonstration
Instructor to Student Ratio is: 1:44
Time of Instruction: 2 hrs
Media: ACTUAL EQUIPMENT

Motivator

In order to regulate patients to facilities that are capable of providing the care required, it is important that you maintain current information on those facilities. As information such as bed status, surgical backlog and basic unit information changes, you must be able to update that information in your database files.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Maintain MEDREG Transaction Files.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the MEDREG application software installed.
Standards:	The soldier must maintain MEDREG transaction files IAW AISM-25-HKD-RZW-ECC-UM, MEDREG User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This lesson will provide you with the ability to maintain MEDREG transaction files allowing you to keep up to date information on the facilities to which you regulate patients. In addition, you will learn the method of archiving this data to maintain historical files on the units.

SECTION III. PRESENTATION

A. ENABLING LEARNING OBJECTIVE A

ACTION:	Maintain facility status.
CONDITIONS:	Given a COTS with the MEDREG application software installed.
STANDARDS:	The soldier must maintain facility status using MEDREG IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Update a Unit's Bed Status using the Automated Communication Menu

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

Present this activity using the HCSSA MEDREG lesson, Automated Communications, ELO 1 thru 4.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Update Unit Bed Status using the Facility Status & Unit Information Menu

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

This information is extracted from HCSSA Lesson, MEDREG System Setup

From the MEDREG Main Menu:

1. Select (1) Facility Status & Information Menu.
2. Press [F1] Execute
3. Select (2) Update Facility Status
4. Press [F1] Execute
5. Press [F1] Query MTF
6. Press [F6] SELECT and enter MTF you would like to query
7. Press RETURN to access that unit
8. Press [F7] UPDATE BED STATUS

NOTE: A message will appear: "Are you going to enter a New Bed Status Report? (y/n)

9. Enter "y"
10. Enter data from the screen.
11. Press [F1] SAVE DATA

NOTE: A message will appear: "Is the information correct and ready to be updated now? (y/n)

12. Enter "y"

NOTE: A message will appear: "The Medical Treatment Facility Status was successfully UPDATED."

13. Press [F8] QUIT SCREEN

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	Maintain unit information.
CONDITIONS:	Given a COTS with the MEDREG application software installed.
STANDARDS:	The soldier must maintain unit information using MEDREG IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Identify each of the MEDREG unit types

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

Present this activity using HCSSA lesson, MEDREG System Setup, ELO 1.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Enter the Unit Information for each unit type

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

Present this activity using HCSSA lesson, MEDREG System Setup, ELO 2.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Update a unit's information

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

Present this activity using HCSSA lesson, MEDREG System Setup, ELO 3.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Delete a unit

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

Present this activity using HCSSA lesson, MEDREG System Setup, ELO 4.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	Maintain select tables.
CONDITIONS:	Given a COTS with the MEDREG application software installed.
STANDARDS:	The soldier must maintain select tables using MEDREG IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Maintain the Medical Specialty Tables

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

Present this activity using HCSSA lesson, System Maintenance, ELO 5.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Maintain the Military Occupational Specialty Tables

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

Present this activity using HCSSA lesson, System Maintenance, ELO 6.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

D. ENABLING LEARNING OBJECTIVE D

ACTION:	Maintain historical data.
CONDITIONS:	Given a COTS with the MEDREG application software installed.
STANDARDS:	The soldier must maintain historical data using MEDREG IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Prepare an Evacuation Request History file

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

Present this activity using HCSSA lesson, Maintain Historical Data, ELO 1.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Archive an Evacuation Request History file

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

Present this activity using HCSSA lesson, Maintain Historical Data, ELO 2 & 3.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Archive a Bed Status History file

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:18
Media: ACTUAL EQUIPMENT

Present this activity using HCSSA lesson, Maintain Historical Data, ELO 4 & 5.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. **SUMMARY**

Method of Instruction: Demonstration
Instructor to Student Ratio is: 1:44
Time of Instruction: 0 hrs
Media: ACTUAL EQUIPMENT

Review / Summarize Lesson

During this lesson we have demonstrated the methods used to maintain various files that are important to you as a medical regulator. We have looked at the ways to:

- Maintain a facilities status, by receiving automatic communications from the facility and by entering the data manually.

- Maintain up to date information about the unit

- Maintain select tables, such as specialty capabilities of the units

- Maintain historical data, such as evacuation request history and bed status history, including how to archive this data and remove it from your system.

Check on Learning

Conduct a check on learning and summarize the lesson.

SECTION V. STUDENT EVALUATION

Testing Requirements

NOTE: Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.

Feedback Requirement

NOTE: Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

PRACTICAL EXERCISE SHEET PE1-HPABG72D

Title

Maintain Facility Status

Lesson Number/Title

HPABG72D version 1 / Maintenance of MEDREG Transaction Files

Introduction

This is the first of four exercises which will evaluate your ability to maintain MEDREG transaction files. In this exercise you will be evaluated on your ability to maintain up to date facility status information, such as bed status, surgical backlog, etc.

Motivator

As treatment facilities receive and evacuate patients, their ability to treat additional patients changes. In order to regulate patients to facilities that are capable of providing the care required, it is important that you maintain current information on those facilities. As information such as bed status, surgical backlog and basic unit information changes, you must be able to update that information in your database files.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Maintain MEDREG Transaction Files.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the MEDREG application software installed.
Standards:	The soldier must maintain MEDREG transaction files IAW AISM-25-HKD-RZW-ECC-UM, MEDREG User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This lesson will provide you with the ability to maintain MEDREG transaction files allowing you to keep up to date information on the facilities to which you regulate patients. In addition, you will learn the method of archiving this data to maintain historical files on the units.

Resource Requirements	Instructor Materials: Student Materials:
Special Instructions	Prior to administering the exercise, instructors must prepare scenarios which match the exercise requirements.
Procedures	**SITUATION:** You have received updated bed status information from several units, both via automatic communications between TAMMIS subsystems, and via radio message. You must enter this information into your system .
Feedback Requirements	

SOLUTION FOR
PRACTICAL EXERCISE SHEET 1

SITUATION: You have received updated bed status information from several units, both via automatic communications between TAMMIS subsystems, and via radio message. You must enter this information into your system .

PRACTICAL EXERCISE SHEET PE2-HPABG72D

Title

Maintain Unit Information

Lesson Number/Title

HPABG72D version 1 / Maintenance of MEDREG Transaction Files

Introduction

This is the second of four exercises which evaluate your ability to maintain MEDREG transaction files.

Motivator

Unit information files provide you with basic information about the facilities you are required to regulate patients to and from. These files provided you with information such as the unit commander, the unit's location, and the preferred means of communication with the unit.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Maintain MEDREG Transaction Files.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the MEDREG application software installed.
Standards:	The soldier must maintain MEDREG transaction files IAW AISM-25-HKD-RZW-ECC-UM, MEDREG User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This exercise evaluates your ability to maintain up to date information about the various units with which you deal.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

Prior to administering the exercise, instructors must prepare scenarios which match the exercise requirements.

Procedures

SITUATION: You have received several reports containing updated information about units within your area of responsibility.

You must update your files to ensure the information they contain matches the current situation.

1. A new unit became operational in your area and you must enter its information in your system.
2. A unit has changed command and you must update it's information in your system.
3. A unit has moved from your area of responsibility and you must delete it from your system.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 2

SITUATION: You have received several reports containing updated information about units within your area of responsibility. You must update your files to ensure the information they contain matches the current situation.

1. A new unit became operational in your area and you must enter its information in your system.
2. A unit has changed command and you must update its information in your system.
3. A unit has moved from your area of responsibility and you must delete it from your system.

PRACTICAL EXERCISE SHEET PE3-HPABG72D

Title

Maintain Select Tables

Lesson Number/Title

HPABG72D version 1 / Maintenance of MEDREG Transaction Files

Introduction

This is the third of four exercises which evaluate your ability to maintain MEDREG transaction files.

Motivator

MEDREG Select Tables contain information pertaining to special capabilities of the units to which you regulate patients. Maintaining this information will help ensure that patients are regulated to the facilities most capable of providing the care required.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Maintain MEDREG Transaction Files.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the MEDREG application software installed.
Standards:	The soldier must maintain MEDREG transaction files IAW AISM-25-HKD-RZW-ECC-UM, MEDREG User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This exercise will evaluate your ability to maintain MEDREG Select Tables.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

Prior to administering the exercise, instructors must prepare scenarios which match the exercise requirements.

Procedures

SITUATION: A new unit was activated and assigned as one of your local receiving facilities. The unit has several medical

	specialties that were not available in your area previously. You must now activate these specialties in your system.
Feedback Requirements	

SOLUTION FOR
PRACTICAL EXERCISE SHEET 3

SITUATION: A new unit was activated and assigned as one of your local receiving facilities. The unit has several medical specialties that were not available in your area previously. You must now activate these specialties in your system.

PRACTICAL EXERCISE SHEET PE4-HPABG72D

Title

Maintain Historical Data

Lesson Number/Title

HPABG72D version 1 / Maintenance of MEDREG Transaction Files

Introduction

This is the fourth and final exercise which evaluates you ability to maintain MEDREG transaction files.

Motivator

As you work within MEDREG, the system receives and stores data which, as time goes on, takes up space on the systems hard drive. If this data was not removed on a periodic basis, the system would eventually run out of space and would not be able to function. It's important, therefore, that you be able to remove some of this data from the system and archive it in historical files.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Maintain MEDREG Transaction Files.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the MEDREG application software installed.
Standards:	The soldier must maintain MEDREG transaction files IAW AISM-25-HKD-RZW-ECC-UM, MEDREG User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This exercise evaluates your ability to maintain MEDREG historical files.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

Prior to administering the exercise, instructors must prepare scenarios which match the exercise requirements.

Procedures	**SITUATION:** Per your unit's SOP, you must archive your old evacuation request files, and your unit bed status history files.
Feedback Requirements	

SOLUTION FOR
PRACTICAL EXERCISE SHEET 4

SITUATION: Per your unit's SOP, you must archive your old evacuation request files, and your unit bed status history files.

PART H: MANAGING PATIENT TRANSACTIONS USING MEDICAL PATIENT ACCOUNTING AND REPORTING

The Army developed two training programs for patient administration specialists. The purpose of the first training program is to introduce these specialists to the types of transactions they must manage during a patient's stay in their facilities. The transactions relate to accounting for the patient, the patient's medical record, and annotations of changes in the patient's status. The second program teaches patient administration specialists how to use the MEDPAR system to generate and manage a variety of reports. The reports go to those involved in future planning, budgeting, and staffing.

Although the Army developed the training materials, the content is equally applicable and usable throughout the Military Health System.

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG028
TSP Title	Managing Patient Transactions using Medical Patient Accounting and Reporting (MEDPAR)
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose

This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for:

This TSP
Contains

TABLE OF CONTENTS

HPABG028 version 1 / Managing Patient Transactions Using MEDPAR
28 May 1998

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
513-71G10	Patient Admin Specialist
513-71G10 (RC)	Patient Admin Specialist (RC)

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0222	Conduct Admission Transactions Using MEDPAR
081-866-0223	Manage Patient Status Using MEDPAR
081-866-0224	Conduct Patient Records Management Using MEDPAR
081-866-0225	Conduct Disposition Transactions Using MEDPAR
081-866-0226	Send an Evacuation Request Using MEDPAR

Academic Hours

The Academic hours required to teach this TSP are as follows:

	ADT Hours/Methods
	6.0 / Demonstration
Test	0.0 /
Test Review	0.0 /
Total Hours:	6.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
HPABG004	Patient Transfer
HPABG005	Introduction to Admissions and Dispositions
HPABG006	Admissions and Dispositions
HPABG026	COTS Components and Operations
HPABG027	Load TAMMIS Software in COTS
HPABG036	Introduction To Keyboarding

Clearance Access

Security Level : Unclassified
Requirements : There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
AISM 25-HKD-RZW-ECC-UM	Automated Information Systems Manual; MEDPAR HKD 04-02; User Manual	26 Aug 1996	

Student Study Assignments

None

Instructor Requirements

One (1) MOS 71G, MEDPAR Qualified Instructor.

Additional Personnel Requirements

None

Equipment Required for Instruction

Name	Quantity	Expendable
Commercial-Off-The-Shelf (COTS) System	0	No

Materials Required

Instructor Materials: None
Student Materials: None

Classroom, Training Area, and Range Requirements

Ammunition Requirements

Name	Student Qty	Misc Qty
None		

Instructional Guidance

NOTE: Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material.

This lesson is to be presented using the following lessons prepared by HCSSA:

LP3 - Patient Admissions
LP7 - Patient Status Management
LP6 - Patient Record Management
LP12 - Patient Evacuations
LP4 - Patient Discharges

Proponent Lesson Plan Approvals

Name	Rank	Position	Date

SECTION II. **INTRODUCTION**

Method of Instruction: Demonstration
Instructor to Student Ratio is: 1:44
Time of Instruction: 6 hrs
Media: ACTUAL EQUIPMENT

Motivator

During a patient's stay in your MTF, there are many transactions you may be called upon to perform to maintain accountability of the patient, manage the patient's records, and annotate any changes in the patient's status.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage patient transactions.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the Medical Patient Accounting & Reporting (MEDPAR) application software installed.
Standards:	The soldier must manage patient accountability using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM, TAMMIS Equipment Operators Course User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This lesson introduces you to the transactions you may be required to perform to manage a patient during his/her stay in your facility.

SECTION III. PRESENTATION

A. ENABLING LEARNING OBJECTIVE A

ACTION:	Conduct admission transactions.
CONDITIONS:	Given a Commercial Off-the-Shelf System (COTS) with the MEDPAR application software installed.
STANDARDS:	The soldier must manage patient admission transactions using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Perform Admit Direct

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP3, Patient Admissions, ELO 1.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Admit an Absent Sick Patient

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP3, Patient Admissions, ELO 2.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Admit a Transfer Patient

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP3, Patient Admissions, ELO 3.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Admit a CRO Patient

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP3, Patient Admissions, ELO 4.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Register Pre-Admission

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP3, Patient Admissions, ELO 5.

NOTE: Conduct a check on learning and summarize the learning activity.

6. Learning Step / Activity 6. Update a Patient Admission

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP3, Patient Admissions, ELO 6.

NOTE: Conduct a check on learning and summarize the learning activity.

7. Learning Step / Activity 7. Delete a Patient Admission

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP3, Patient Admissions, ELO 7.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	Manage the patient's status.
CONDITIONS:	Given a Commercial Off-the-Shelf System (COTS) with the MEDPAR application software installed.
STANDARDS:	The soldier must manage patient status using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Exercise the Inter-ward Transfer Function

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP7, Patient Status Management, ELO 1.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Exercise the SI to VSI Function

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP7, Patient Status Management, ELO 2.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Complete a Change of Status Out Transaction

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP7, Patient Status Management, ELO 3.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Complete a Change of Status In Transaction

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP7, Patient Status Management, ELO 4.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Delete Change of Status In Transaction

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP7, Patient Status Management, ELO 5.

NOTE: Conduct a check on learning and summarize the learning activity.

6. Learning Step / Activity 6. Delete Change of Status Out Transaction

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP7, Patient Status Management, ELO 6.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	Conduct patient records management.
CONDITIONS:	Given a Commercial Off-the-Shelf System (COTS) with the MEDPAR application software installed.
STANDARDS:	The soldier must manage patient record management using MEDPAR IAW

	AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Create an Inpatient Treatment Record Cover Sheet (ITRCS)

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP6, Patient Record Management, ELO 1.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Create Patient Labels

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP6, Patient Record Management, ELO 2.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Print Patient Stay Records

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP6, Patient Record Management, ELO 3.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Archive Patient Records

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP6, Patient Record Management, ELO 4.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Restore a Patient Record

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP6, Patient Record Management, ELO 5.

NOTE: Conduct a check on learning and summarize the learning activity.

6. Learning Step / Activity 6. Remove Old Archive Records

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP6, Patient Record Management, ELO 6.

NOTE: Conduct a check on learning and summarize the learning activity.

7. Learning Step / Activity 7. Send SIDRs to PAS&BA

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP6, Patient Record Management, ELO 7.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

D. ENABLING LEARNING OBJECTIVE D

ACTION:	Conduct patient evacuation transactions using MEDPAR.
CONDITIONS:	Given patient information, a computer with COTS hardware and MEDPAR software, and a MEDPAR User's Manual.
STANDARDS:	Soldier must conduct patient evacuation transactions using MEDPAR IAW the

	MEDPAR User's Manual.

1. Learning Step / Activity 1. Print a Patient Evacuation Request Worksheet

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP12, Patient Evacuations, ELO 1.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Maintain Evacuation Status

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP12, Patient Evacuations, ELO 2.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Print the Reports from MEDREG

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP12, Patient Evacuations, ELO 4.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Update Maintain Evacuation Status with Information from MEDREG

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP12, Patient Evacuations, ELO 5.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Prepare a Patient Manifest

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP12, Patient Evacuations, ELO 6.

NOTE: Conduct a check on learning and summarize the learning activity.

6. Learning Step / Activity 6. Send Transfer Data to the Gaining MTF

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP12, Patient Evacuations, ELO 7.

NOTE: Conduct a check on learning and summarize the learning activity.

7. Learning Step / Activity 7. Load Transfer Data from a Losing MTF

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP12, Patient Evacuations, ELO 8.

NOTE: Conduct a check on learning and summarize the learning activity.

8. Learning Step / Activity 8. Print a Patient Evacuation Roster

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP12, Patient Evacuations, ELO 9.

NOTE: Conduct a check on learning and summarize the learning activity.

9. Learning Step / Activity 9. Send the Bed Status Report to MEDREG

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP12, Patient Evacuations, ELO 10.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

E. ENABLING LEARNING OBJECTIVE E

ACTION:	Send an evacuation request.
CONDITIONS:	Given a Commercial Off-the-Shelf System (COTS) with the MEDPAR application software installed.
STANDARDS:	The soldier must send an evacuation request using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Send an Evacuation Request to MEDREG

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP12, Patient Evacuations, ELO 3.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

F. ENABLING LEARNING OBJECTIVE F

ACTION:	Conduct patient disposition transactions.
CONDITIONS:	Given a Commercial Off-the-Shelf System (COTS) with the MEDPAR application software installed.
STANDARDS:	The soldier must conduct patient disposition transactions using MEDPAR IAW

1. Learning Step / Activity 1. Discharge an Active Duty Patient Back to Duty (RTD)

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP4, Patient Discharges, ELO 1.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Discharge a Family Member from the Hospital

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP4, Patient Discharges, ELO 2.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Discharge Transfer a Patient

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP4, Patient Discharges, ELO 3.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Discharge a Patient being Retired/Separated from Service

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP4, Patient Discharges, ELO 4.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Discharge a Patient due to Death

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP4, Patient Discharges, ELO 5.

NOTE: Conduct a check on learning and summarize the learning activity.

6. Learning Step / Activity 6. Discharge an Absent Without Leave (AWOL) Patient

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP4, Patient Discharges, ELO 6.

NOTE: Conduct a check on learning and summarize the learning activity.

7. Learning Step / Activity 7. Update a Patient Discharge

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP4, Patient Discharges, ELO 7.

NOTE: Conduct a check on learning and summarize the learning activity.

8. Learning Step / Activity 8. Delete a Patient Discharge

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP4, Patient Discharges, ELO 8.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. **SUMMARY**

Method of Instruction: Conference / Discussion

Instructor to Student Ratio is: 1:44
Time of Instruction: 0 hrs
Media: None

Review / Summarize Lesson

During this lesson we have demonstrated the methods you will use to manage patients in your MTF, using the MEDPAR system. Topics we have discussed are:

Conducting admission transactions
Conducting disposition transactions
Managing patient status
Managing patient records

Conducting patient evacuation transactions and sending an evacuation request

Check on Learning

Conduct a check on learning and summarize the lesson.

SECTION V. STUDENT EVALUATION

Testing Requirements

NOTE: Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.

Feedback Requirement

NOTE: Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

PRACTICAL EXERCISE SHEET PE1-HPABG028

Title

Conduct Admission Transactions

Lesson Number/Title

HPABG028 version 1 / Managing Patient Transactions Using MEDPAR

Introduction

This is the first in a series of practical exercises that will be used to evaluate your ability to use the MEDPAR system.

Motivator

As explained during this lesson and in previous lessons on admissions and dispositions, there are several types of admissions. You need to be able to perform any of these functions.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage patient transactions.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the Medical Patient Accounting & Reporting (MEDPAR) application software installed.
Standards:	The soldier must manage patient accountability using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM, TAMMIS Equipment Operators Course User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This exercise will evaluate your ability to perform the various admission functions in the MEDPAR system.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

Procedures

SITUATION: Given a list of patients with necessary information to include the type of admission, complete the following admission transactions:

1. Admit Direct
2. Admit Absent Sick
3. Transfer Admit
4. Admit CRO
5. Register Pre-admission
6. Update admission information
7. Delete an admission

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 1

SITUATION: Given a list of patients with necessary information to include the type of admission, complete the following admission transactions:

1. Admit Direct
2. Admit Absent Sick
3. Transfer Admit
4. Admit CRO
5. Register Pre-admission
6. Update admission information
7. Delete an admission

PRACTICAL EXERCISE SHEET PE2-HPABG028

Title

Manage Patient Status

Lesson Number/Title

HPABG028 version 1 / Managing Patient Transactions Using MEDPAR

Introduction

This is the second in a series of practical exercises designed to evaluate your ability to use the MEDPAR system.

Motivator

During a patient's stay in your MTF, there may be instances in which you are required to update or change the status of the patient, such as placing the patient on convalescent leave or transferring the patient from one ward to another.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage patient transactions.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the Medical Patient Accounting & Reporting (MEDPAR) application software installed.
Standards:	The soldier must manage patient accountability using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM, TAMMIS Equipment Operators Course User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This lesson introduces you to the transactions you may be required to perform to manage a patient during his/her stay in your facility.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

Procedures

SITUATION: Given a list of previously admitted patients whose status has changed, perform the following Patient Status Management functions:

1. Perform an Inter-ward Transfer
2. Change a patient's status from SI to VSI
3. Place a patient on convalescent leave (Change of Status Out)
4. Return a patient from convalescent leave (Change of Status In)
5. Delete a Change of Status In transaction
6. Delete a Change of Status Out transaction

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 2

SITUATION: Given a list of previously admitted patients whose status has changed, perform the following Patient Status Management functions:

1. Perform an Inter-ward Transfer
2. Change a patient's status from SI to VSI
3. Place a patient on convalescent leave (Change of Status Out)
4. Return a patient from convalescent leave (Change of Status In)
5. Delete a Change of Status In transaction
6. Delete a Change of Status Out transaction

PRACTICAL EXERCISE SHEET PE3-HPABG028

Title

Manage Patient Records

Lesson Number/Title

HPABG028 version 1 / Managing Patient Transactions Using MEDPAR

Introduction

This is the third in a series of exercises which evaluate your ability to perform Patient Management functions using the MEDPAR system.

Motivator

Management of patient's records is of critical importance. There are several functions in the MEDPAR system that help you carry out this responsibility.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage patient transactions.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the Medical Patient Accounting & Reporting (MEDPAR) application software installed.
Standards:	The soldier must manage patient accountability using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM, TAMMIS Equipment Operators Course User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This exercise evaluates your ability to perform Patient Record Management functions using the MEDPAR system.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

Procedures

SITUATION: Given a list of previously admitted patients, perform the following Patient Record Management functions:

1. Create an Inpatient Treatment Record Cover Sheet (ITRCS)
2. Create Patient Labels
3. Print Patient Stay Records
4. Archive Patient Records
5. Restore Patient Records
6. Remove Old Archive Records
7. Send SIDRs to PAS&BA

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 3

SITUATION: Given a list of previously admitted patients, perform the following Patient Record Management functions:

1. Create an Inpatient Treatment Record Cover Sheet (ITRCS)
2. Create Patient Labels
3. Print Patient Stay Records
4. Archive Patient Records
5. Restore Patient Records
6. Remove Old Archive Records
7. Send SIDRs to PAS&BA

PRACTICAL EXERCISE SHEET PE4-HPABG028

Title

Conduct Patient Evacuation Transactions

Lesson Number/Title

HPABG028 version 1 / Managing Patient Transactions Using MEDPAR

Introduction

This is the fourth in a series of exercises which evaluate your ability to perform Patient Management functions using the MEDPAR system.

Motivator

Patient evacuation in a timely manner is essential to avoiding overcrowding of the MTF and delaying any treatment required by the patient.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage patient transactions.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the Medical Patient Accounting & Reporting (MEDPAR) application software installed.
Standards:	The soldier must manage patient accountability using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM, TAMMIS Equipment Operators Course User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This exercise along with PE 5, evaluates your ability to prepare a patient for evacuation using the MEDREG system.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

This practical exercise should be conducted in conjunction with PE5, Send an Evacuation Request.

Procedures

SITUATION: Given a list of patients requiring evacuation, any special instructions, and their movement categories, perform the

following Patient Evacuation functions:

1. Print a Patient Evacuation Request Worksheet
2. Maintain the patient's Evacuation Status by entering patient data

NOTE: PE 5, Send an Evacuation Request should be conducted at this time.

3. Print Reports from MEDREG
4. Maintain Evacuation Status by entering information for an approved evacuation from MEDREG
5. Prepare a Patient Manifest
6. Send Transfer Data to the gaining MTF
7. Load Transfer Data from a losing MTF
8. Print a Patient Evacuation Roster
9. Send the Bed Status Report to MEDREG

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 4

SITUATION: Given a list of patients requiring evacuation, any special instructions, and their movement categories, perform the following Patient Evacuation functions:

1. Print a Patient Evacuation Request Worksheet
2. Maintain the patient's Evacuation Status by entering patient data

NOTE: PE 5, Send an Evacuation Request should be conducted at this time.

3. Print Reports from MEDREG
4. Maintain Evacuation Status by entering information for an approved evacuation from MEDREG
5. Prepare a Patient Manifest
6. Send Transfer Data to the gaining MTF
7. Load Transfer Data from a losing MTF
8. Print a Patient Evacuation Roster
9. Send the Bed Status Report to MEDREG

PRACTICAL EXERCISE SHEET PE5-HPABG028

Title

Send an Evacuation Request

Lesson Number/Title

HPABG028 version 1 / Managing Patient Transactions Using MEDPAR

Introduction

This is the fifth in a series of exercises that evaluate your ability to perform Patient Management functions using the MEDPAR system.

Motivator

Once the determination has been made to evacuate the patient, you must be able to communicate this requirement to the medical regulators to ensure a timely evacuation.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage patient transactions.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the Medical Patient Accounting & Reporting (MEDPAR) application software installed.
Standards:	The soldier must manage patient accountability using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM, TAMMIS Equipment Operators Course User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This exercise evaluates your ability to communicate with the MEDREG system ensuring patient evacuations are carried out as required.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

This exercise should be conducted in conjunction with PE 4, Conduct Patient Evacuation Transactions.

Procedures

SITUATION: Given a list of patients requiring evacuation,

1. Send an Evacuation Request to MEDREG

NOTE: The means of communication will vary depending on the equipment on hand.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 5

SITUATION: Given a list of patients requiring evacuation,

1. Send an Evacuation Request to MEDREG

NOTE: The means of communication will vary depending on the equipment on hand.

PRACTICAL EXERCISE SHEET PE6-HPABG028

Title

Conduct Disposition Transactions

Lesson Number/Title

HPABG028 version 1 / Managing Patient Transactions Using MEDPAR

Introduction

This is the sixth of a series of exercises which evaluate your ability to perform Patient Management functions using the MEDPAR system.

Motivator

The final step in managing a patient during his/her stay in your facility is to discharge the patient once that decision has been made.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage patient transactions.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the Medical Patient Accounting & Reporting (MEDPAR) application software installed.
Standards:	The soldier must manage patient accountability using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM, TAMMIS Equipment Operators Course User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

This exercise evaluates your ability to perform the various Patient Discharge transactions using the MEDPAR system.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

Procedures

SITUATION: Given a list of patients requiring discharge from your facility and the reason for discharge, perform the following Patient

Discharge transactions:

1. Discharge Return to Duty.
2. Discharge from Hospital
3. Discharge Transfer
4. Discharge Retired/Separated from Service
5. Discharge Death
6. Discharge AWOL
7. Update a Patient Discharge
8. Delete a Patient Discharge

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 6

SITUATION: Given a list of patients requiring discharge from your facility and the reason for discharge, perform the following Patient Discharge transactions:

1. Discharge Return to Duty.
2. Discharge from Hospital
3. Discharge Transfer
4. Discharge Retired/Separated from Service
5. Discharge Death
6. Discharge AWOL
7. Update a Patient Discharge
8. Delete a Patient Discharge

TRAINING SUPPORT PACKAGE (TSP)

TSP Number	HPABG029
TSP Title	Managing/Producing Medical Patient Accounting and Reporting (MEDPAR) Reports
Task Number(s) / Title(s)	
Effective Date	
Supercedes TSP(s)	
TSP Users	
Proponent	The proponent for this document is ACAD OF HEALTH SCIENCES.
Comments / Recommen-dations	Send comments and recommendations directly to: ACADEMY OF HEALTH SCIENCES ATTN MCCS HS 2250 STANLEY ROAD STE 246 FORT SAM HOUSTON, TX 78234-6150 Or e-mail: NETA_LESJAK@SMTPLINK.MEDCOM.AMEDD.ARMY.MIL
Foreign Disclosure Restrictions	This product has been reviewed by the product developers in coordination with the AMEDD foreign disclosure authority. This product is releasable to military students from foreign countries on a case-by-case basis.

PREFACE

Purpose	This Training Support Package provides the instructor with a standardized lesson plan for presenting instruction for:

This TSP
Contains

TABLE OF CONTENTS

HPABG029 version 1 / Managing/Producing MEDPAR Reports
28 May 1998

SECTION I. ADMINISTRATIVE DATA

All Courses Including This Lesson

Course Number	Course Title
513-71G10	Patient Admin Specialist
513-71G10 (RC)	Patient Admin Specialist (RC)

Task(s) Taught(*) or Supported

Task Number	Task Title

Reinforced Task(s)

Task Number	Task Title
081-866-0227	Produce Facility Management Reports Using MEDPAR
081-866-0229	Process a Worldwide Workload Report (WWR) using MEDPAR
081-866-0230	Produce User Defined Reports Using MEDPAR
081-866-0231	Transmit Reports Using MEDPAR

Academic Hours

The Academic hours required to teach this TSP are as follows:

	ADT Hours/Methods
	4.0 / Demonstration
Test	0.0 /
Test Review	0.0 /
Total Hours:	4.0

Prerequisite Lesson(s)

Lesson Number	Lesson Title
HPABG026	COTS Components and Operations
HPABG027	Load TAMMIS Software in COTS
HPABG028	Managing Patient Transactions Using MEDPAR
HPABG030	Worldwide Workload Reports

Clearance Access

Security Level : Unclassified
Requirements : There are no clearance or access requirements for the lesson.

References

Number	Title	Date	Additional Information
AISM 25-HKD-RZW-ECC-UM	Automated Information Systems Manual; MEDPAR HKD 04-02; User Manual	26 Aug 1996	

Student Study Assignments

None

Instructor Requirements

One (1) MOS 71G, MEDPAR Qualified Instructor.

Additional Personnel Requirements

None

Equipment Required for Instruction

Name	Quantity	Expendable
Commercial-Off-The-Shelf (COTS) System	0	No

Materials Required

Instructor Materials: None
Student Materials:
MEDPAR Users Manual
Access to EVEREX System

Classroom, Training Area, and Range Requirements

Ammunition Requirements

Name	Student Qty	Misc Qty
None		

Instructional Guidance

NOTE: Before presenting this lesson, Instructors must thoroughly prepare by studying this lesson and identified reference material.

This lesson is to be taught using the USAMISSA developed MEDPAR lessons:
- Facility Management Reports
- Patient Accounting Reports
- Worldwide Workload Reports
- User Defined Reports

Students and instructor must have access to the EVEREX COTS System and a copy of the MEDPAR User's Manual as described in the Reference Section of this TSP

Proponent Lesson Plan Approvals

Name	Rank	Position	Date

SECTION II. **INTRODUCTION**

Method of Instruction: Demonstration
Instructor to Student Ratio is: 1:44
Time of Instruction: 4 hrs
Media: ACTUAL EQUIPMENT

Motivator

Information management systems, such as MEDPAR, are of no real use to us unless we can use the data we have entered into the system to our advantage. This lesson will provide you with the skills you need to use the data in the MEDPAR system to produce a variety of reports, thereby allowing you to share the data with others who can use it for such things as future planning, budgeting, staffing, etc.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage Medical Patient Accounting & Reporting (MEDPAR) reports.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the MEDPAR application software installed.
Standards:	The soldier must manage MEDPAR reports using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM TAMMIS User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

In previous lessons you have learned how to enter patient data into the MEDPAR system, and you have also learned about several reports that are based on patient data. This lesson will tie those lessons together and show you how to use the MEDPAR system to generate and manage these reports.

SECTION III. PRESENTATION

A. ENABLING LEARNING OBJECTIVE A

ACTION:	Produce management reports.
CONDITIONS:	Given a Commercial Off-the-Shelf System (COTS) with the MEDPAR application software installed.
STANDARDS:	The soldier must produce management reports using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Print a Command Interest Roster

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA Lesson, 'Facility Management Reports.'

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Print an Expected Dispositions Report

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA Lesson, 'Facility Management Reports.'

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Print a Bed Status Report

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA Lesson, 'Facility Management Reports.'

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Print a Register Number Listing

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA Lesson, 'Facility Management Reports.'

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Print a Pre-Admission Report

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA Lesson, 'Facility Management Reports.'

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

Administer PE1 as a check on learning for this ELO.

B. ENABLING LEARNING OBJECTIVE B

ACTION:	Produce Patient Accounting Reports.
CONDITIONS:	Given a COTS with the MEDPAR application software installed.
STANDARDS:	The soldier must produce Patient Accounting Reports using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Print a Ward Report

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP8, Patient Accounting Reports, ELO 1.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Print an Admissions and Dispositions Report

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP8, Patient Accounting Reports, ELO 2.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Print a Recapitulation Report

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP8, Patient Accounting Reports, ELO 3.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Print an Allied Admissions and Dispositions Report

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP8, Patient Accounting Reports, ELO 4.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Perform AAD Corrections

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP8, Patient Accounting Reports, ELO 5.

NOTE: Conduct a check on learning and summarize the learning activity.

6. Learning Step / Activity 6. Print a VSI/SI/SPECAT Roster

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP8, Patient Accounting Reports, ELO 6.

NOTE: Conduct a check on learning and summarize the learning activity.

7. Learning Step / Activity 7. Print a Patient Alpha Roster

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP8, Patient Accounting Reports, ELO 7.

NOTE: Conduct a check on learning and summarize the learning activity.

8. Learning Step / Activity 8. Print a Patient Roster by Unit

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP8, Patient Accounting Reports, ELO 8.

NOTE: Conduct a check on learning and summarize the learning activity.

9. Learning Step / Activity 9. Print a Reportable Conditions Roster

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP8, Patient Accounting Reports, ELO 9.

NOTE: Conduct a check on learning and summarize the learning activity.

10. Learning Step / Activity 10. Print a Length of Patient Stay Roster

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP8, Patient Accounting Reports, ELO 10.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

Administer PE 2 as a check on learning for this ELO.

C. ENABLING LEARNING OBJECTIVE C

ACTION:	Process a Worldwide Workload Report (WWR).
CONDITIONS:	Given a COTS with the MEDPAR application software installed.
STANDARDS:	The soldier must produce a WWR using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Enter WWR Outpatient Data

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP9-1, Worldwide Workload Reports, ELO 1.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Update WWR Outpatient Data

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA, LP9-1, Worldwide Workload Reports, ELO 2.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Print an Interim Report

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP9-1, Worldwide Workload Reports, ELO 3.

NOTE: Conduct a check on learning and summarize the learning activity.

4. Learning Step / Activity 4. Print a Monthly WWR

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP9-1, Worldwide Workload Reports, ELO 4.

NOTE: Conduct a check on learning and summarize the learning activity.

5. Learning Step / Activity 5. Print a Corrected WWR

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP9-1, Worldwide Workload Reports, ELO 5.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

D. ENABLING LEARNING OBJECTIVE D

ACTION:	Produce User-defined reports.
CONDITIONS:	Given a COTS with the MEDPAR application software installed.
STANDARDS:	The soldier must produce User-defined reports using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Print the User Report File Structure

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP13, User Defined Reports, ELO 1.

NOTE: Conduct a check on learning and summarize the learning activity.

2. Learning Step / Activity 2. Create, Modify, and Print a User Defined Report

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP13, User Defined Reports, ELO 2.

NOTE: Conduct a check on learning and summarize the learning activity.

3. Learning Step / Activity 3. Modify the Print/Display Options for a User Defined Report

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

Present this activity using USAMISSA , LP13, User Defined Reports, ELO 3.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

E. ENABLING LEARNING OBJECTIVE E

ACTION:	Transmit reports.

CONDITIONS:	Given a COTS with the MEDPAR application software installed.
STANDARDS:	The soldier must transmit reports using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM.

1. Learning Step / Activity 1. Transmit MEDPAR Reports

Method of Instruction: Demonstration
Instructor to Student Ratio: 1:44
Media: ACTUAL EQUIPMENT

NOTE: Several of the reports generated in the MEDPAR system may be transmitted to other facilities as required. Although these reports are accessed through different menu options, once the report to be transmitted has been selected, the procedure to transmit the report is similar. Therefore, for our purposes we will demonstrate the procedure using the Worldwide Workload Report.

A. Select the "Send Worldwide Workload Report" menu item.

NOTE: Two fields appear on the screen, REPORT TYPE, and REPORTING PERIOD.

B. Enter the appropriate information in the fields on the screen.

1. Report Type

a. Corrected
b. Final
c. Monthly
d. Initial

2. Reporting Period

NOTE: The previous month is the default value.

C. Press [F1] Send File:

NOTE: You may send data using a modem or MS-DOS formatted floppy disks, a Select table will appear with your options. If you select Send by Floppy (Drive A or B) the following message appears:

Please insert floppy. Press [Return] to continue.

Insert the diskette in the appropriate drive and press [Return]. Once the data has been transferred to the floppy diskette, you will receive the following message:

The transaction file was sent.

If you select Send by Modem, you will receive the following messages:

Sending File. Please wait.
The transaction file has been queued to be sent.

If the communication fails for any reason you will receive the message:

The Transaction File could not be sent. Error Code (xx).

D. Exit the screen by pressing [F8] Return to Menu.

NOTE: Conduct a check on learning and summarize the learning activity.

CHECK ON LEARNING: Conduct a check on learning and summarize the ELO.

SECTION IV. **SUMMARY**

Method of Instruction:	Demonstration
Instructor to Student Ratio is:	1:44
Time of Instruction:	0 hrs
Media:	ACTUAL EQUIPMENT

Review / Summarize Lesson	This lesson has introduced you to the various reports that can be produced using the MEDPAR system. Your ability to generate and print these reports will be crucial in allowing your commanders and other interested people the ability to make important decisions related to patient accountability, staffing, capabilities and future planning for your MTF.
Check on Learning	Conduct a check on learning and summarize the lesson.

SECTION V. STUDENT EVALUATION

Testing Requirements

NOTE: Describe how the students will be tested to determine if they can perform the TLO standard. Refer student to the Student Evaluation Plan.

Feedback Requirement

NOTE: Rapid, immediate feedback is essential to effective learning. Schedule and provide feedback on the evaluation and any information to help answer students' questions about the test. Provide remedial training as needed.

PRACTICAL EXERCISE SHEET PE1-HPABG029

Title

Producing Management Reports

Lesson Number/Title

HPABG029 version 1 / Managing/Producing MEDPAR Reports

Introduction

This exercise will check your ability to produce the various facility management reports using the MEDPAR system.

Motivator

Facility Management Reports allow commanders and other interested parties to review the capability of the MTF and make decisions pertaining to current patient load.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage Medical Patient Accounting & Reporting (MEDPAR) reports.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the MEDPAR application software installed.
Standards:	The soldier must manage MEDPAR reports using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM TAMMIS User's Manual.

Safety Requirements

IAW local SOP.

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

Once you select the report you desire to print from the Facility Management Reports menu, the procedures are basically the same, to generate any report.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

Procedures

1. Select the appropriate menu item (report) from the Facility Management Reports menu.

2. Press [F1] Execute.

3. Review the messages that appear on the screen.

4. Print the report.

   Enter "N" at the prompt to automatically print the report and enter "1" for the number of copies.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 1

1. Select the appropriate menu item (report) from the Facility Management Reports menu.

2. Press [F1] Execute.

3. Review the messages that appear on the screen.

4. Print the report.

   Enter "N" at the prompt to automatically print the report and enter "1" for the number of copies.

PRACTICAL EXERCISE SHEET PE2-HPABG029

Title

Producing Patient Accounting Reports

Lesson Number/Title

HPABG029 version 1 / Managing/Producing MEDPAR Reports

Introduction

This exercise will check your ability to produce the various reports available in the Patient Accounting Reports menu.

Motivator

Patient Accounting Reports allows the user to print rosters and reports concerning the accountability of patients in the facility.

Terminal Learning Objective

NOTE: Inform the students of the following Terminal Learning Objective requirements.

At the completion of this lesson, you [the student] will:

Action:	Manage Medical Patient Accounting & Reporting (MEDPAR) reports.
Conditions:	Given a Commercial Off-the-Shelf System (COTS) with the MEDPAR application software installed.
Standards:	The soldier must manage MEDPAR reports using MEDPAR IAW AISM-25-HKD-RZW-ECC-UM TAMMIS User's Manual.

Safety Requirements

IAW local SOP

Risk Assessment Level

Low

Environmental Considerations

N/A

Evaluation

Instructional Lead-In

In previous lessons you have learned how to enter patient data into the MEDPAR system, and you have also learned about several reports that are based on patient data. This lesson will tie those lessons together and show you how to use the MEDPAR system to generate and manage these reports.

Resource Requirements

Instructor Materials:

Student Materials:

Special Instructions

Procedures

1. Select the appropriate menu item (report) from the Patient Accounting Reports menu.

2. Press [F1] Execute.

3. Review the messages that appear on the screen.

4. Print the report.

Enter "N" at the prompt to automatically print the report and enter "1" for the number of copies.

Feedback Requirements

SOLUTION FOR
PRACTICAL EXERCISE SHEET 2

1. Select the appropriate menu item (report) from the Patient Accounting Reports menu.

2. Press [F1] Execute.

3. Review the messages that appear on the screen.

4. Print the report.

Enter "N" at the prompt to automatically print the report and enter "1" for the number of copies.